# PAVING THE WAY FOR RCH

## Tools for Quality and Gender Mainstreaming

**Women Centred Health Project**

Public Health Department of
Municipal Corporation of Greater Mumbai

Society for Health Alternatives (SAHAJ)

Royal Tropical Institute

**Other Publications :**

1. ***'Gatha Stree Arogyachi'*** — a resource book on reproductive health for health workers (Marathi)
2. Puja Roy, **Women Centred Health Project, Prioritising Urban Women's Health Issues in a Public Health System, Mumbai, India,** The International Council on Management of Population Programe (ICOMP), November 2001
3. **Mainstreaming Quality Assurance in the Public Health Department, Mumbai, India**
4. **Training Manual on Women's Health for Clinicians**
5. **Training Manual for Counselling in Gynaecology Clinics**
6. **Stepping Stones : Training Manual for Communication on Sexuality (Marathi)**
7. **Counselling Booth in a Gynaecology Out Patient Clinic : An Evaluation Report**

**IEC Material Produced :**

1. ***'Mahiticha Bagicha'*** (Wall chart on Reproductive Tract Infections, Marathi)
2. Pamphlet on RTIs (Hindi and Marathi)
3. Pamphlets on MTP (Hindi and Marathi)
4. Pamphlets on ANC (Hindi and Marathi)

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# ABBREVIATIONS

| | |
|---|---|
| AB | Abortion |
| ACASH | Association for Consumers' Action for Safety and Health |
| AHO | Assistant Health Officer |
| AIDS | Acquired Immuno-Deficiency Syndrome |
| AMC | Additional Municipal Commissioner |
| ANC | Ante Natal Care |
| ANM | Auxiliary Nurse Midwife |
| BCG | Vaccine against tuberculosis |
| MCGM | Brihanmumbai Municipal Corporation |
| BP | Blood Pressure |
| BPL | Below Poverty Line |
| CBO | Community Based Organisation |
| CDO | Community Development Officer |
| CHV | Community Health Volunteer |
| CME | Continuing Medical Education |
| Cu-T | Copper T |
| DEHO | Deputy Executive Health Officer |
| Del. | Delivery |
| Disp | Dispensary |
| DMC | Deputy Municipal Commissioner |
| DOTS | Directly Observed Treatment Short course |
| DPT | Vaccine against diphtheria, pertusis and tetanus |
| ED | Expected date |
| EDD | Expected date of delivery |
| EDL | Essential Drug List |
| EHO | Executive Health Officer |
| F | Female |
| FP | Family Planning |
| FS | Ferrous Sulphate |
| FTMO | Full Time Medical Officer |
| FW & MCH | Family Welfare and Mother Child Health |
| G/N | G/North (one of the 24 administrative wards of Mumbai, where WCHP was piloted) |
| Gyn./ Gynaec. | Gynaecological |
| H/E | H/East (one of the 24 administrative wards of Mumbai, where WCHP was piloted) |
| HHs | Households |
| HIV | Human Immuno-deficiency Virus |
| Hosp. | Hospital |
| Hrs. | Hours |
| ICPD | International Conference on Population and Development |
| IEC | Information Education Communication |
| IPP-V | India Population Project – V |
| ISDT | Integrated Skill Development Training |
| Jr.MOH | Junior Medical Officer of Health |
| K/E | K/East (One of the 24 administrative wards of Mumbai) |
| KEM | King Edward VII Memorial Hospital (Largest teaching hospital owned by the Municipal Corporation of Greater Mumbai |
| KIT | Royal Tropical Institute |
| LB | Live births |
| LSTM | Liverpool School of Tropical Medicine |
| M | Male |
| Mar. | Marriage |
| Mat.Home | Maternity Home |

| | |
|---|---|
| MB | Mahiticha Bagicha - Informative broadsheet/wall chart on Reproductive Tract Infection |
| MCGM | Municipal Corporation of Greater Mumbai |
| MDACS | Mumbai District AIDS Control Society |
| MHADA | Maharashtra Housing and Development Authority |
| MIS | Management Information System |
| MO | Medical Officer |
| MO i/c | Medical Officer in charge |
| MOH | Medical Officer of Health |
| MPW | Multipurpose Worker — Male |
| MS | Marital status |
| MSL | Vaccine against measles |
| MTP | Medical Termination of Pregnancy |
| NA | Not Applicable |
| NGO | Non-Governmental Organisation |
| NLEP | National Leprosy Eradication Programme |
| NSV | Non Scalpel Vasectomy |
| OPD | Out-patient Department |
| OPV | Oral Polio Vaccine |
| ORS | Oral Rehydration Solution |
| PC | Patients' Charter of Rights and Responsibilities |
| PHC | Primary Health Care |
| PHD | Public Health Department |
| PHN | Public Health Nurse |
| PID | Pelvic Inflammatory Diseases |
| PPC | Post Partum Centre |
| PV | Per Vaginum |
| QA | Quality Assurance |
| QoC | Quality of Care |
| RCH | Reproductive and Child Health |
| RH | Reproductive Health |
| RNTCP | Revised National Tuberculosis Control Programme |
| RS | Ranking System |
| RTI | Reproductive Tract Infection |
| SAHAJ | Society for Health Alternatives |
| SB | Still births |
| SG | Support Group |
| Sl. No. | Serial Number |
| SOFW | Special Officer (Family Welfare) |
| STD | Sexually Transmitted Disease |
| STG | Standard Treatment Guideline |
| STI | Sexually Transmitted Infection |
| TB | Tuberculosis |
| TISS | Tata Institute of Social Science |
| TL | Tubal Ligation |
| TT | Tetanus Toxoide |
| UK | United Kingdom |
| Vit A | Vitamin A |
| WCHP | Women Centred Health Project |
| WHCs | Women's Health Centres |
| WG | Working Group |
| Wt. | Weight |

# LIST OF ANNEXES

# LIST OF TOOLS

# ACKNOWLEDGMENTS

On behalf of the team, we wish to convey our heartfelt gratitude to those who helped in the implementation of the Women Centred Health Project. This would not have been possible without the support of Dr A. S. Karande (former Executive Health Officer, MCGM) and Dr R. M. Kathuria (Executive Health Officer, MCGM). Their faith encouraged the team throughout the course of the project. At various points in the project Dr J. V. Telang, Dr B. K. Dhir, Dr S. R. Kakhandki and Dr G. K. Koparde, Deputy Executive Health Officers in charge of Maternal and Child Health and Family Welfare, provided the administrative support essential for the implementation of a participatory action research project that actively involved health care providers from all cadres.

Dr N. K. Kewalramani, then Assistant Health Officer for IEC, showed keen interest in the development of participatory IEC material. She played a key role in developing the informative poster '*Mahiticha Bagicha*' and conveying the principles of client-friendly interactive IEC to grassroots health care workers.

Dr J. G. Thanekar and Dr P. S. Keskar, then DEHO and AHO respectively of the ASHA Project of MCGM, helped in the implementation of the community development methodology based on an adaptation of the 'Stepping Stones' manual[1] through MCGM.

Special thanks are due to the members of the Support Group and Working Group who initiated the development of the Patients' Charter of Rights and Responsibilities and the Ranking System. Their efforts motivated the project to continue with the struggle for mainstreaming QA in the public health system.

The project was implemented primarily in the H/E and G/N wards of the MCGM. Dr S. H. Hemdev, Dr B. G. Harale, Dr P. D. Malviya, and Dr J. A. Khandare and Dr K. M. Harugoli, as Medical Officers of Health for the two wards, helped in the day-to-day implementation of various activities. Dr B.G. Harale and Dr J. A. Khandare helped expand the project activities to wards E and A respectively, thereby demonstrating the feasibility of these services in the MCGM. Dr Siddiqui (MOH K/E) encouraged the initiation of gynaecology clinics in two health posts in K/E.

Ms Varsha Joshi (H/E), Mr Satish Sonegaokar (G/N) and Mr Ashok Ramteke (K/E) — Community Development Officers — actively participated in many of the project activities. They played a key role in ensuring the active participation of grassroots health care workers from their respective wards in the project's activities.

Dr Neeta Joshi, Dr Pushpa Moorjani and Dr Redkar, all ex-medical

[1] *Stepping Stones: A training package on HIV/AIDS, communication and relationship skills by Alice Welbourn*

superintendents, and Dr Mangat, the medical superintendent for V.N. Desai Municipal Secondary Hospital, supported the project in setting up a counselling centre at the gynaecology outpatient clinic of the hospital. We thank them for their help and trust in us. We also thank Dr Bhatki, Chief Medical Superintendent, for granting us permission to establish the counselling centre at the hospital.

Various committees, with health care workers and administrators as members, guided the course taken by the project. We are grateful to all the members for their active participation.

In the three years between 2000 and 2003, the project initiated eight gynaecology clinics in health posts and dispensaries. Medical officers, PHNs, ANMs, MPWs, CHVs, attendants and other staff at these facilities deserve appreciation. Their willingness to experiment strengthened the project's resolve to continue despite difficulties.

We conducted a number of research studies in the process of exploring strategies for implementing the project. These would not have been possible without the kind cooperation of respondents that included men and women from the communities, clients seeking services at the gynaecology out-patient clinic at the V.N.Desai hospital and at health posts, dispensaries, maternity homes and post partum centres, health care providers and CHVs. We thank them all for enriching our knowledge.

Ms Vicki Doyle, Dr Dave Haran, consultants from Women's Health Studies Group from LSTM, shaped the QA component of the project. In the early phase of the project Mr Sunil Nandraj and Mr Ravi Duggal provided consultancy to the project. Dr Lalita Maydeo, Dr Kanchan Kumtha and Dr Shubha Dukle reviewed the manuals and the IEC material developed by the project from a gynaecologist's perspective. We are grateful for their contribution.

We are also grateful to all the key trainers and resource persons who contributed in the various training programmes organised by the project and gave their expert feedback on a number of project documents. Their suggestions helped improve the quality of the production.

And finally, while the entire team contributed to putting together this document, we acknowledge the special efforts of Anagha Pradhan in compiling the fact sheets and the tools.

**Usha Ubale** **Renu Khanna** **Korrie de Koning**

# INTRODUCTION

## The Project

The Women Centred Health Project (WCHP) is a joint initiative of the Public Health Department of the Municipal Corporation of Greater Mumbai (MCGM) – – also known as the Brihanmumbai Municipal Corporation (BMC) — and the Society for Health Alternatives (SAHAJ), a non-governmental organisation located in Baroda. WCHP receives technical support from the Liverpool School of Tropical Medicine (LSTM), UK and the Royal Tropical Institute, Amsterdam (KIT). The project came into existence in 1996 with the goal of improving the quality of health care services, especially those related to women's reproductive health, provided through the health care facilities managed by the Public Health Department of the MCGM and expanding the range of services for reproductive health offered by these centres.

The Women Centred Health Project was developed to address the needs expressed by women who participated in an earlier (1993–96) research study which explored the social and clinical factors affecting and predisposing slum women to pelvic inflammatory diseases (PID). WCHP was planned as an action research project to evolve a model for the provision of women-centred health care with an emphasis on sexual and reproductive health and to integrate the needs-based services into the existing health care delivery system. The project aimed at making existing municipal services women friendly and gender sensitive.

The project initiated a number of activities to meet these objectives. The experience of the project in working with the public health system — successes and difficulties faced in implementation of activities — was presented to senior and middle-level administrators of the Public Health Department at a workshop organised on 7 July 2000. The first draft of 'Paving the Way' was prepared for this workshop.

Apart from the experiences and findings of the WCHP, this document provides recommendations for designing Mumbai's soon-to-be-introduced urban

Reproductive and Child Health Programme (Phase II). The experiences of the project offer important lessons for the implementation of a comprehensive reproductive and child health (RCH) programme and include feasible ways for ensuring quality of clinical as well as client-friendly practices and implementation of a social and rights based-approach to reproductive health. In addition, the document also lists the expectations of various cadres of senior and middle-level administrators.

## About This Document

The present document was updated in September 2003 to include successes, difficulties and lessons learned by the project between July 2000 and September 2003. This updated version integrates important experiences that gathered momentum after July 2000 and enriched the understanding of ways to introduce the concepts of gender, clients' rights and men's involvement in sexual and reproductive health into the mainstream activities of the Public Health Department. Other issues absent in the first draft include:

- The training methodology and content for the Integrated Skills Development Training (ISDT) of the National Reproductive and Child Health programme (RCH),
- Initiation of gynaecology clinics at municipal primary healthcare centres (health posts and dispensaries),
- Establishment of a counselling centre at the gynaecology out-patient clinic of a secondary hospital, and
- The project's work with male health workers.

Lessons learned are presented through fact sheets for each of the major activities undertaken by the project. Various tools used for monitoring and evaluation are attached as annexes to the fact sheets. The achievements presented in this document — which is primarily a summary process documentation of the project — are substantiated by the end-evaluation.

The various activities of the project are categorised into three main parts for ease of presentation. Part I describes strategies for building the capacity of

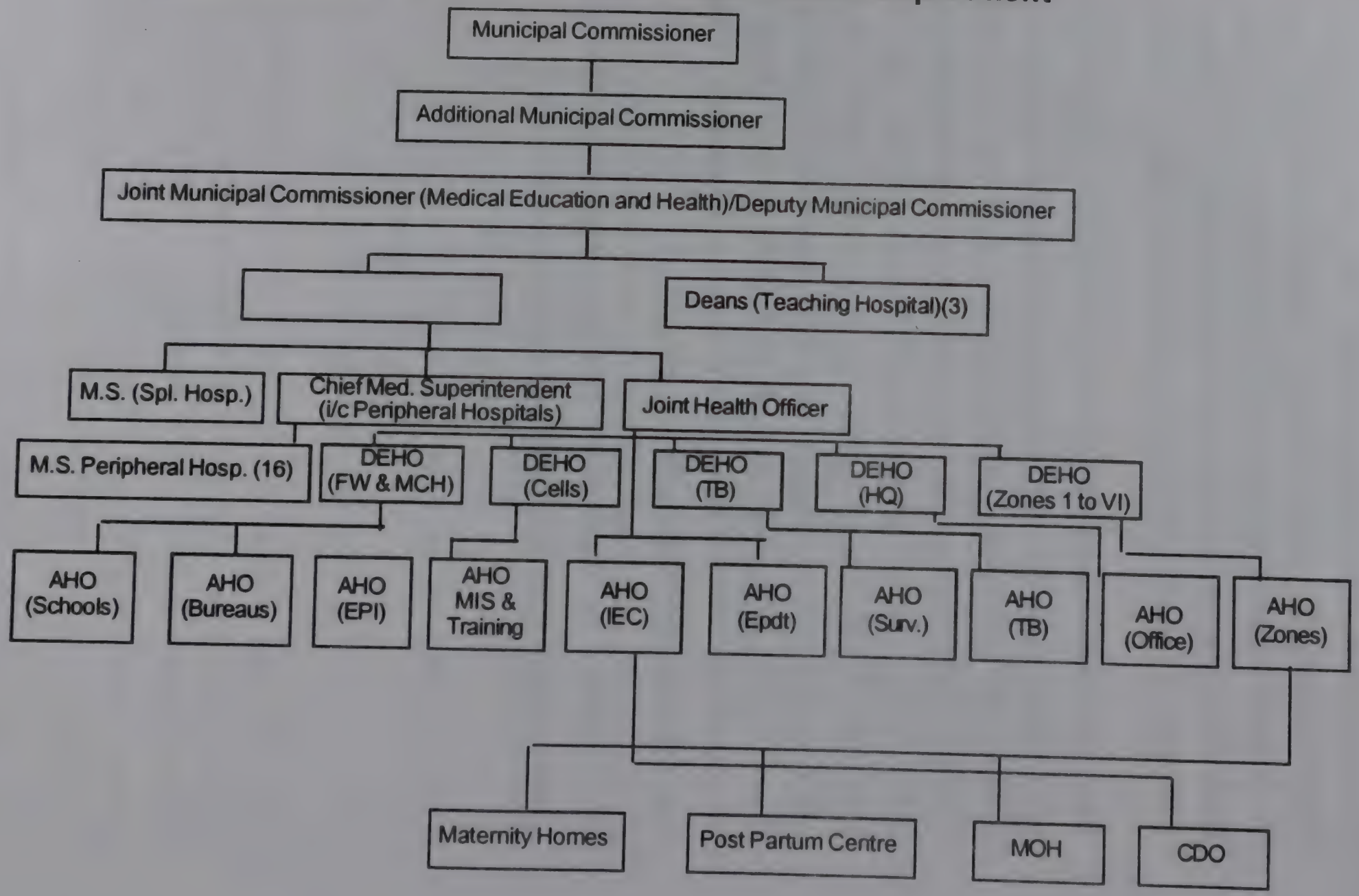
municipal health care providers. Part II presents pilot interventions that demonstrated the feasibility of improving quality of reproductive healthcare provided by the municipal health care facilities. Convinced that the lessons learned from the project could help MCGM successfully implement urban RCH II, the project undertook advocacy at local, state, national and international levels. Part III of the document presents salient points of the advocacy efforts undertaken by the project for the implementation of urban RCH II in Mumbai.

Each fact sheet includes the rationale for the intervention, activities, achievements, constraints, recommendations and suggestions for the role of various health supervisors and administrators. Though the designations mentioned in the fact sheets refer to those from the Public Health Department of MCGM, the fact sheets will be useful to all those trying to work within the public health system. The fact sheets and accompanying tools will also be of use to non-governmental organisations involved in mainstreaming gender and quality into the public health systems. To facilitate use of the project's experiences, an overview of its inputs and the resources contributed by MCGM is provided with all the fact sheets.

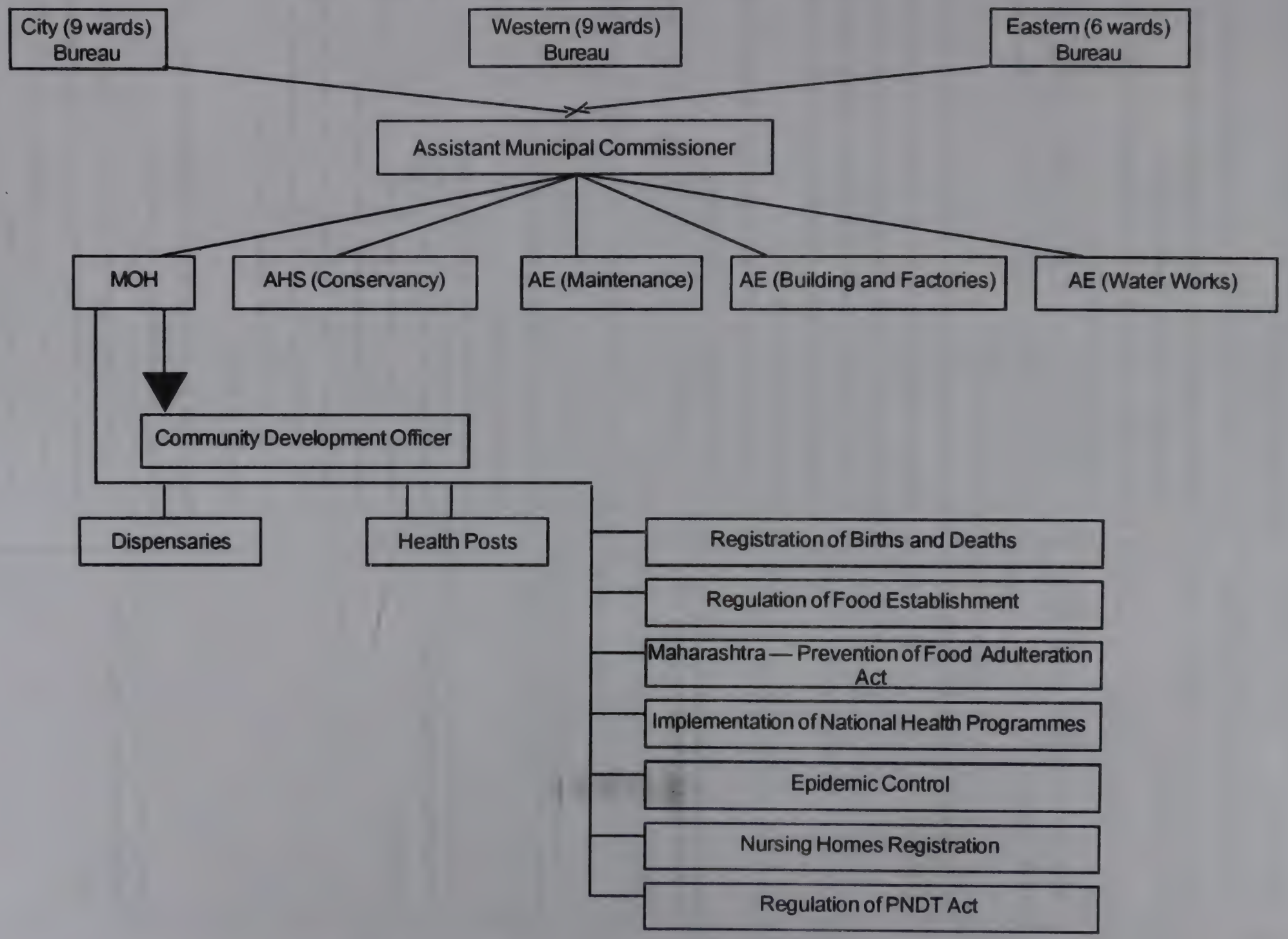
The structure of the Public Health Department of MCGM and the main responsibilities of some of its key designations are presented in Annex 1.

**Annex 1**

## Administrative Structure of the Public Health Department



## Administrative Structure at Ward Level



# KEY DESIGNATIONS OF THE PUBLIC HEALTH DEPARTMENT OF MCGM AND THEIR RESPONSIBILITIES

| Designation | Main responsibilities |
|---|---|
| Deputy Executive Health Officer (Family Welfare and Maternal and Child Health): DEHO (FW&MCH) | • In charge of all health posts, dispensaries and maternity homes managed by the Public Health Department of the Municipal Corporation of Greater Mumbai (MCGM)<br>• Key person for implementation of all programmes through the health posts and dispensaries |
| Deputy Executive Health Officer (Cells): DEHO (Cells) | • Responsible for the IEC, Training and MIS Cells of MCGM.<br>• Key person in planning and implementation of activities related to IEC, training and MIS |
| Deputy Executive Health Officer (Zone): DEHO (Zone) | • For administrative purposes, the area of Mumbai is divided into 24 wards that are grouped into six zones. Each zone consists of four to six wards. DEHO (Zones) is the administrative supervisor for one of the zones. This person is responsible for the smooth functioning of health posts, dispensaries and maternity homes in the zone assigned to her/him.<br>• Key person for routine monitoring, review of facility-level activities and for problem solving at facility level. |
| Assistant Health Officer (Training): AHO (Training) | • Responsible for the Training Cell of MCGM. Reports to DEHO (Cells).<br>• Key person for the development, planning and implementation of all training programmes conducted by MCGM. |
| Assistant Health Officer (IEC): AHO (IEC) | • Responsible for all IEC activities of MCGM. Supervisor of all CDOs.<br>• Key person in development of IEC material. |
| Assistant Health Officer (Bureau): AHO (Bureau) | • For administrative purposes the 24 wards are divided into three bureaus — City, Western and Eastern. The AHO (Bureau) is responsible for the administration and supervision of health posts in each bureau. Drugs for health posts are indented from the bureau. Performance reports from health posts are also compiled at bureau level. Bureau offices have a budget for repairs and purchase of drugs.<br>• Responsible for monthly review of health posts. Key person for organising and coordinating of resources. |
| Assistant Health Officer (Zone): AHO (Zone) | • Is an administrative supervisor for the zone. This person is responsible for smooth functioning of health posts, dispensaries and maternity homes in the zone assigned to her/him. The AHO (Zone) reports to the DEHO (Zone).<br>• Key person for routine monitoring, review of facility-level activities and for problem solving at facility level. |

| Designation | Main responsibilities |
|---|---|
| Special Officer—— Family Welfare (SOFW) | • Responsible for post partum centres.<br>• Key person for ensuring implementation of all programmes related to family welfare.<br>• Liaison person between MCGM and the Government of Maharashtra.<br>• Responsible for monitoring family welfare activities and resource reorganisation. |
| Medical Officer of Health: (MOH) | • Administrative head at ward level. Responsible for routine supervision of all activities implemented through health posts and dispensaries in that particular ward. Reports to DEHOs and AHOs.<br>• Key person in routine monitoring, supportive supervision of health posts, dispensaries and maternity homes.<br>• Can help in reorganising resources and problem solving. |
| Community Development Officer: (CDO) | • Social worker by training, the CDO is attached to one of the wards (all 24 wards have CDOs).<br>• Responsible for planning and implementation of all IEC activities at ward level.<br>• Key persons for planning awareness programmes, programmes for special days<br>• Carries out routine monitoring of health posts and dispensaries. |
| Junior Medical Officer of Health: (Jr.MO) | • Doctor by training. Responsible for administrative assistance to the MOH. Also acts as reliever medical officer for the ward. |

***Note**: DEHOs, AHOs and MOHs are doctors by training. DEHOs and AHOs hold a diploma or degree in Public Health. These administrative posts are promotional.*

# PART I

# CAPACITY BUILDING ACTIVITIES

## Introduction

The participatory action research approach of the Women Centred Health Project (WCHP) included a cyclic process of identifying the problems and then planning, implementing and monitoring interventions to discover what is feasible, taking note of the difficulties encountered. This was followed by adaptation and the designing of new interventions in close collaboration with all levels of staff in the Public Health Department (PHD). The aim was to develop appropriate and feasible interventions that would allow for mainstreaming of strategies and lessons learned into the Public Health Department. In order to sustain the positive changes introduced into the system beyond the project's duration, WCHP emphasised capacity building of PHD's health care providers.

The project's capacity building activities were aimed at developing a conducive environment for institutionalising the concepts of gender, sexual and reproductive health, and quality care, quality assurance and a rights perspective within MCGM. Strategies included training workshops for a cross-section of health care providers, reinforcing linkages between departments or cells from within the PHD and formative research conducted in participation with the health care providers and community to gain clarity about the issues concerned. Training formed one of the most important capacity building activities of the project.

This section presents the training implemented by the project and other activities that contributed to enhancing the perspectives and skills of the municipal health care providers.

Tools in this section include pre- and post-training tests for various training workshops, guidelines and checklists developed to ensure quality assurance and session plans for various training workshops conducted with male health workers.

Fact Sheet 1

# TRAINING FOR SEXUAL AND REPRODUCTIVE HEALTH SERVICES

## Rationale

In the focus group discussions and exit interviews conducted in the first phase of the Women Centred Health Project, men and women from the community expressed a need for information on sexual and reproductive health conditions and their treatment closer to home. In order to meet this felt need, the municipal corporation of Mumbai initiated through WCHP a process of expanding the range of services provided at the primary level health care facilities through the establishment of gynaecology clinics. The training component of the project included technical clinical and counselling aspects as well as sessions to sensitise the staff of these facilities to the social determinants of sexual and reproductive health of women and the role of men in women's health. A social and rights approach to reproductive health is an important aspect of the Plan of Action that emerged from the International Conference on Population and Development in Cairo (held in 1994), to which the Indian government is a signatory. The findings of the Mumbai Municipal Corporation in the piloting of expanded sexual and reproductive health interventions will assist in the further implementation of the ICPD declaration by urban-based public health systems. The features differentiating WCHP training from the other training programmes conducted in MCGM are:

- Use of participatory teaching methods.
- Focus on women-centred/ women-friendly approach.
- Inclusion of topics such as gender, communication, social and rights-based approaches to reproductive health.

## Activities

WCHP conducted several training programmes over the last seven years:

1. Four training programmes for key trainers.
2. Two training programmes in four prioritised reproductive health issues for clinicians. A sample of pre- and post-test used for this training is presented in Annex 1.2.
3. One training programme in four prioritised reproductive health issues

for Auxiliary Nurse Midwives (ANMs) and Multipurpose workers (MPWs).

4. Two workshops in four prioritised reproductive health issues for Community Health Volunteers (CHVs).
5. WCHP's Project and Training Coordinators and the Training Officer were key trainers for the Adolescent Girls Initiative — a reproductive and sexual health education programme initiated by the PHD for out-of-school adolescent girls.
6. Two workshops on effective communication and health promotion.
7. Two workshops for the development of participatory IEC materials.
8. One gender sensitisation workshop for senior administrators from MCGM.
9. Two workshops on participatory training techniques for RCH key trainers.
10. Training programme for Public Health Nurses (PHNs) in the use of '*Mahiticha Bagicha*', a wall chart on Reproductive Tract Infections (RTIs).
11. Sessions on building a social and rights perspective on women's health in the Integrated Skills Development Training of the National RCH programme implemented in Mumbai by PHD.
12. Sessions on gender, counselling skills, quality assurance, facilitation skills incorporated in the ISDT of RCH for all cadres of health care providers.
13. Four workshops on Gender and Health for multi-purpose workers (MPWs).
14. Four workshops on communication about sexuality and HIV/AIDS (Stepping Stones).
15. Three workshops providing PHNs, ANMs and MPWs training in counselling.
16. One workshop on skills for family planning counselling.
17. Two workshops for laboratory technicians on diagnosis of reproductive tract infections.

Details of these training programmes are presented in Annex 1.1.

**Other capacity building activities**

Exploratory research studies conducted by the project in partnership with the MCGM health care providers helped orient the providers to all steps of research. The research component of the project is described separately.

## Achievements

- Participatory methodology adopted for in-service training conducted by the PHD, as well as for the Integrated Skills Development Training of the Urban RCH Programme.

- Integration of communication and counselling skills in the training of key trainers from the Training Cell of MCGM for in-service training.
- The formative research carried out among out-of-school adolescents in collaboration with UNICEF contributed to the development of the curriculum for training of trainers of the 'Adolescent Girls Initiative'.
- The training team from WCHP participated in the development of a curriculum for 'Adolescent Girls' Health', a programme undertaken by the Government of Maharashtra for out-of-school adolescent girls.
- Key trainers reported changes in their perspective regarding women's health. Self-reported changes by key trainers indicated that inputs given during the training helped them become 'good listeners' and enhanced their 'articulation skills' and 'analytical abilities'. The use of participatory training methodology was appreciated by the participants of all training programmes.
- 20 of the 30 trainees (ANM/MPW) interviewed at the time of the midterm evaluation reported having applied the knowledge and skills learnt during training to field situations. (See Report of the Evaluation of the Women Centred Health Project.)
- The workshops on gender and sexuality and the community development workshop (Stepping Stones) that were conducted for male health workers (MPWs) providing them with a changed perspective on gender, were among the first such efforts to reach this cadre of staff and improved their ability to communicate about sexual and reproductive health issues. MPWs also reported acquiring confidence in conducting health education sessions in the community.
- All health care providers attending the end-evaluation of the project reported the Stepping Stones Workshop as being the 'most useful',
- Sessions on women's health, counselling, communication, facilitation skills and quality assurance were incorporated into the Integrated Skills Development Training of Urban RCH Programme.
- The counselling training resulted in good quality counselling by counsellors and health workers staffing the counselling centre in a peripheral hospital. (based on observations during the end evaluation)

## Constraints

- Lack of coordination between vertical programmes made it difficult for the staff at primary level facilities to immediately implement lessons learned

after the training programmes, thus adversely affecting consolidation of lessons learned and expansion of services at the primary level.

- Resistance from health workers in conducting the training programmes delayed implementation of the services at facility level.
- Inadequate logistics management and support resulted in delayed implementation of lessons learned after training.
- Activities initiated after training could not be systematically monitored because the administrators could not take time off from their routine duties.
- Additional administrative support is required for MPWs for widening the scope of their work by applying skills and knowledge acquired through workshops.

## Recommendations

- Integrate the adaptations made to the Integrated Skills Development Programme by the Mumbai Municipal Corporation into the training for the National Programme on Reproductive and Child Health (RCH).
- Make intensive counselling training, community development workshops (Stepping Stones) and workshops on gender and sexuality part of the RCH programme.
- Ensure training of community development officers, community health workers, auxiliary nurse midwives and male multipurpose workers in the RCH programme (see Annex 14.2 for a description of their role).
- A common training plan for various vertical programmes needs to be developed to build up a uniform understanding of topics like gender sensitivity, social determinants of health, communication and counselling skills.
- MCGM's Training Cell should be the nodal body in planning and conducting training programmes. This will help avoid repetition of training on the same or related topics and ensure that workshops do not unnecessarily interrupt the routine functions of health posts and dispensaries.
- A team of trainers with representatives from each cadre of staff should be identified and given the responsibility of developing modules for various cadres. For instance, the Public Health Nurses and Community Development Officers (CDOs) trained by the project formed an effective group of trainers and can serve as an important resource for the RCH training programme.
- The use of participatory training methods should be mainstreamed in all MCGM training programmes.

- A monitoring system should be established to ensure that logistics support is in place.
- Training programmes should be evaluated and adapted if necessary through pre- and post-tests.

***Expected Roles of Deputy Executive Health Officer in Charge of Training, IEC and MIS (Deho-Cells) and Deputy Executy Executive Health Officer in charge of Family Welfare and Maternal and Child Health (Deho - FW & MCH)***

- Ensuring coordination between various training programmes, i.e., a Master Training Plan for Public Health Department should be prepared each year.
- Ensuring that a system is in place to monitor implementation of post-training activities.
- Ensuring a regular review of new initiatives and field-level implementation resulting from training inputs during supervisory visits.
- Assisting in organising the logistics and venue for training programmes.

***Expected Role of Assistant Health Officers in Charge of Zones (Zonal AHOs)***

- Monitoring to ensure that Medical Officers of Health (MOsH) provide logistics support to enable immediate implementation after training.
- Regular review with MOsH about newer initiatives.
- Review with staff during monthly meetings about problems encountered.
- Regularly reporting to DEHO (Cells) on progress.

***Expected Role of Assistant Health Officer In Charge Of Training (AHO Training)***

- Specifying the roles of all health workers in the activities that follow the training (post-training implementation). This should form an integral part of each training proposal and be made mandatory.
- Assessing training needs of all cadres with help of MosH.

***Expected Role of Medical Officers of Health (MOsH)***

- Ensuring logistics support for immediate and proper implementation of the activities to be initiated after training.
- Ensuring supportive supervision for problem-solving and implementing new activities.
- Regular monitoring of post-training activities.

- Helping and guiding staff in time management whenever ad hoc programmes like the census are being undertaken, so that existing activities, especially services to the community, are not affected.
- Organising regular meetings to inform the AHO about problems and progress.

***Expected Role of Community Development Officers (CDOs)***

- Identifying training needs of the field staff.
- Identifying resource persons.
- Developing proposals.
- Developing pre- and post-evaluation tools for participatory training.
- Arranging for the analysis of the evaluation forms and organising feedback meetings.
- Conducting sessions related to the social aspects of health.

## Contribution of Resources for Training

| Resources contributed by MCGM | Resources contributed by the Project |
|---|---|
| • Permission to all participants to attend the workshop<br>• Venue | • Venue<br>• Development of session outline of the workshop<br>• Identifying resource persons<br>• Organisation of workshop<br>• Stationary and other material required during the training<br>• Refreshments for participants<br>• Honorarium for the resource persons |

***Note**: Contributions for all training workshops by the project were essentially same. Hence details are not provided for specific training workshops that are presented as fact sheets in this section.*

### List of Annexes

Annex 1.1: Details of the Training Programmes Conducted by WCHP

### List of Tools

T-1.1 : A sample of pre- and post-tests used for training programmes in four prioritised reproductive health issues for clinicians.

## Annex 1.1

# Details of the Training Programmes

| Training | Content | Training conducted by | Trainees |
|---|---|---|---|
| Training of Trainers (TOT) | • Principles and philosophy of participatory training<br>• Participatory methods of training<br>• Communication and counselling skills<br>• Gender and health<br>• Perspective building for women's health | • WCHP staff | 4 Full-time Medical Officers (Medical Officers in charge of health posts) (FTMO)<br>1 Medical Officer i/c Dispensary<br>5 Public Health Nurses<br>5 Auxiliary Nurse Midwives<br>3 Multipurpose Workers (MPWs)<br>**(WCHP Key Trainers: Total 18)** |
| Training on Reproductive Tract Infections | • RTIs (technical and social aspects)<br>• Treatment-seeking behaviour of men and women for RTIs<br>• Attitudinal change<br>• Gender<br>• When to refer<br>• Record keeping<br>• Beliefs and practices<br>• Role of CHVs | • WCHP staff | 60 Community Health Volunteers<br>Training of CHVs in 3 Gynaecology OPDs |
| Training in Participatory Training Methodology | • Key concepts of participatory training techniques<br>• Understanding self as learner and trainer<br>• Methods and techniques of participatory training<br>• Working together effectively<br>• Learning with reference to the adult learner | • Department of Extra-Mural Studies, Tata Institute of Social Science (TISS) | Key trainers for Reproductive and Child Health Programme in Mumbai |
| Follow-up Training | • Preparation of sessions<br>• Presentations<br>• Feedback | • WCHP staff | Key trainers for Reproductive and Child Health Programme in Mumbai |
| Concept of Health Promotion | • Socio-economic factors affecting health<br>• Biological perspective of health<br>• Health education vs. health promotion<br>• Planning of IEC strategies | • WCHP staff | 17 members of Information, Education and Communication core group established by WCHP |
| Effective Communication I | • Process of communication<br>• Effect of personal biases, attitudes in communication | • External resource persons<br>• WCHP staff | 17 members of the Information, Education and Communication core group established by WCHP |
| Effective Communication II | • Self-assessment and inter-personal communication skills<br>• Behavioural change<br>• Body language and visuals | • External resource persons<br>• WCHP staff | 17 members of the Information, Education and Communication core group established by WCHP |
| Preparing Participatory IEC Materials on RTIs | • Principles of participatory material development<br>• Creating stories and pictures based on perceptions of community men and women<br>• Pre-testing the IEC materials | • External resource persons<br>• WCHP staff | 17 members of the Information, Education and Communication core group established by WCHP and NGO representatives |

| Training | Content | Training conducted by | Trainees |
|---|---|---|---|
| Sexuality and Gender | • Sexuality<br>• Women's anatomy<br>• Difference between personal and professional values<br>• Sexual values<br>• Sexual responses and men's involvement<br>• Sexual problems in women<br>• FP methods | • Family Planning Association of India, Mumbai<br>• External resource persons<br>• WCHP | 12 male multipurpose workers from G/North Ward and 11 male multipurpose workers from H/East Ward<br>(2 training workshops) |
| Gender Sensitivity Training | • Understanding gender<br>• Gender and its implication for health<br>• Gender-sensitive health care services<br>• Gender-specific interventions<br>• Practical and strategic gender needs<br>• Plan for making the PHD of MCGM gender sensitive | • External resource person | Senior MCGM officers |
| Convergence Workshop | • Presentations by all national programme heads of MCGM<br>• Presentations on expectations from health care providers of MCGM for different programmes<br>• Presentations on roles of different categories of health care providers at health post and dispensary levels<br>• Plan of action for integrated health care centre<br>• Presentation on integrated MIS | • MCGM Senior Officers<br>• WCHP staff | Health care providers of MCGM |
| Gender and Health | • Concepts of Gender, Sexuality, Reproductive Health<br>• Relation between gender and health and its differential impact on men and women | • External resource persons | 26 male mult-purpose workers<br>3 Community Development Officers<br>WCHP representatives |
| Facilitation Skills | • Different training methods<br>• Importance of participatory training in adult learning<br>• Facilitation skills<br>• Concepts of theatre forum | • External resource persons | 12 male multipurpose workers from H/E, G/N, K/E wards<br>2 Community Development Officers<br>WCHP representatives |
| Gender, Health and Facilitation Skills | • Difference between sex and gender<br>• Gender-based discrimination<br>• Facilitation skills<br>• Importance of participatory training methodology | • External resource persons | 14 male multipurpose workers<br>5 doctors (key trainers for Reproductive and Child Health Programme in Mumbai)<br>1 Community Development Officer<br>WCHP representatives |
| Theatre forum | • Technique of theatre forum (participatory role–play) | • External resource persons | 14 male multipurpose workers<br>4 Community Development Officers<br>5 Social work students<br>Street play<br>Group of IEC cell of MCGM |

| Training | Content | Training conducted by | Trainees |
|---|---|---|---|
| Stepping Stones Workshops (6 batches) | • Trust and confidentiality<br>• Listening skills<br>• Body language<br>• Ideal images and personal destroyers | • Key trainers from MCGM<br>• Training Coordinator of WCHP | 2 representatives of WCHP<br>11 Community Development Officers<br>13 Public Health Nurses<br>45 male multipurpose workers<br>6 representatives of MCGM AIDS Cell<br>Medical officers in charge of health posts (FTMOs), medical officers in charge of dispensaries, Public Health Nurses, Auxiliary Nurse Midwives and male multipurpose workers from all health posts where gynaecology clinics are initiated<br>Representatives from School Health Department of MCGM<br>Representatives from all wards of MCGM |

## T-1.1

# A Sample of Pre- and Post - Tests Used for Training Programmes in Four Prioritised Reproductive Health Issues for Clinicians

**1. What are the criteria for normal pregnancy?**

***Expected Answer:***

*Delivery of a single baby in good condition between 38 and 42 weeks by date, with a foetal weight of 2.5 kg or more and with no maternal complications.*

**Maximum marks – 5**

**2. What are the causes of oedema of the feet in pregnancy?**

***Expected Answer:***

- *Physiological*
- *Pre-eclampsia*
- *Anaemia*
- *Hypo proteinaemia*
- *Cardiac failure*
- *Nephrotic syndrome*

**Maximum marks – 3**

**3. What are the risk factors for which the woman needs to be referred to a specialist in obstetrics and gynaecology? List at least five risk factors.**

***Expected Answer:***

- *Age more than 35 yrs.*
- *IUGR*
- *Hb < 10 gms %*
- *Parity more than 5*
- *Multiple pregnancy*
- *Cardiac diseases*
- *History of bleeding during pregnancy*
- *Blood pressure > 130/90 mm of Hg*
- *Height < 4 1/2 Ft.*
- *History of leaking per vagina*
- *Diabetes*
- *History of 2 or more abortions*
- *Polyhydramniosis*

**Maximum marks — 5**

**4. On abdominal examination, the fundus is palpable at the level of navel. What is the gestation period ?**

***Expected Answer :*** *24 weeks*

**Maximum marks — 1**

**5. A woman, having a two–year-old child, is registered with you for**

TOOL

**antenatal care. She is three months pregnant. In the previous pregnancy she has received two doses of T.T. How many doses of T.T. will you advise in the present pregnancy?**

***Expected Answer :*** *One dose*

**Maximum marks — 1**

**6. At what gestational age does the foetal heart become audible?**

***Expected Answer :*** *24–26 weeks*

**Maximum marks — 1**

**7. Fill the blanks**

**Maximum marks — 1 each**

(a) A sperm count of ***20-200 million*** is normal.

(b) If semen report is abnormal, repeat semen analysis is required to be done ***three*** times before investigating the woman.

**8. What investigations are required to find the causative organism in a woman complaining of white discharge?**

***Expected Answer:***

- *Wet mount*
- *Gram stain*
- *Culture*

**Maximum marks — 3**

**9. Give the treatment for Candida albicans.**

***Expected Answer:***

***Local*** - *Clotrimazole / Miconazole*
- *Vaginal pessaries - 1 HS/3 days or*
  *Nystalin vaginal pessaries 1,00, 000 u for 14 days*

***Oral*** - *Tablet Sysconazole 150 mg/1 day*
*or Tab Ketaconazole 2 tabs for 5 days*

***Treat male partner***

**Maximum marks — 3**

**10. What is the treatment if mucopus is seen on per speculum examination?**

***Expected Answer:***

- *Tab Doxycycline 100 mg/b.d./7 days or*
- *Tetracycline 500 mg/g. ds/7 days*
- *Tab Erythromicin 500 mg/ g.d.s/7 days*
- *Treat partners*

**Maximum marks — 2**

**11. What are the gender issues in white discharge and leucorrhoea?**

***Expected Answer :***

- *Women are usually too shy to talk about white discharge*
- *Woman found with RTI may be labelled a 'loose woman'*
- *Decision-makers of the family like mother-in-law will take woman to the health centre for problems in pregnancy or infertility rather than for 'trivial' symptoms like excessive vaginal discharge*
- *Women are taught to silently suffer problems related to their reproductive organs*
- *Reluctance to seek health services due to inadequate sex education and less access to medical care*
- *White discharge is generally regarded by women as 'normal' and a fact of their existence as women. It is considered stigmatising. When it interferes with their prescribed functions and they have to take treatment.*

**Maximum marks — 3**

**12. (a) List five barriers of communication with patients.**

**(b) Suggest ways to overcome any one of them.**

***Expected Answers:***

*a) Barriers to communication* **Maximum marks — 5**

***1. Personality factors***

- *Judgemental attitude, biases, prejudices*
- *lack of warmth and concern*
- *insensitive*
- *distance due to class difference*
- *talking from power position , top-down approach — "I know – you don't, I will tell you,"*
- *inhibition and shyness to communicate in case of STD and reproductive organs*

***2. Lack of rapport-building skills***

- *lack of rapport*
- *not listening to them*
- *no eye contact*

***3. Skills in information giving***

- *use of medical jargon*
- *too much information given at a time*
- *language*
- *non-use of appropriate audio visuals*
- *not having proper knowledge*

- *not trained*

4. ***External factors***

- *time constraint*
- *noisy place*

5. ***Gender factor***

- *male doctor*

*b) Suggestions to overcome the barriers* **Maximum marks — 7**

***Expected Answers:***

***1. Personality factors***

- *A conscious survey of knowledge, attitude, biases, etc., should be undertaken and an attempt should be made to be non-judgemental, not exclaiming and understanding*

2. ***Rapport-building skills***

- *Verbal and body language skills should be practised*
- *Even if there is a long queue, show an interest even in the last patient and try to establish rapport*
- *Show her that you are interested in her and respect her*

3. ***Information giving skills***

- *Proper selection of audiovisuals will definitely reinforce suitable messages*

4. ***External factors***

- *Lean towards her and ask her in a soft voice which others around do not hear in a crowded OPD*
- *Try to ensure privacy at least with a curtain 5. Gender factor*
- *A male doctor senstive to gender and women's health problems can overcome barriers due to gender factor.*

**13. How can you help the woman understand the information that you are giving her? (Any three)**

***Expected Answers:***

1. ***Finding out what information she needs***

- *Start from her level, first find out what and how much she already knows about the topic*
- *Give relevant and necessary information*
- *Avoid giving complex and unnecessary details which might confuse her*

2. ***Planning and organising the information — phase out the information***

- *Give accurate information*
- *Give the information in an organised and logical manner*

3. ***Making the sessions interactive***

- *Encourage the woman to ask questions*
- *Observe non-verbal communication and respond to her needs and doubts*

4. ***Language and delivery***

- *Use simple language, avoid using jargon*
- *Use of local terminology*

5. ***Use of A/V material***

**Maximum marks — 5**

**14. How can you reduce shyness and fear of a woman who is going for internal examination? (Any three)**

***Expected Answer:***

1. ***Rapport building***

- *Say: I know how you feel — every woman is bound to feel shy and apprehensive (if you are a lady doctor you could say that this is exactly what you felt when you had your first internal) but please remember I have done many such examinations before, and I will try not to hurt you.*
- *Do a general examination first so that she gets to know you and builds her confidence in you*
- *Be reassuring*

2. ***Preparation***

- *Preparing and telling her in case of a male doctor*
- *Giving her time to prepare physically*
- *Preparing her mentally and taking her consent*
- *Providing privacy for removing or loosening her underclothes*

3. ***Explanation***

- *Explaining the examination procedure (what and why)*

4. ***Privacy during examination***

- *Covering her with a sheet during examination*
- *See that no one else enters while the examination is being done*

5. ***Respect***

- *Tell her to take the position in respectful and caring way*

6. ***Make her feel comfortable during examination***

- *Keep talking to her and keep the easy conversation flowing (ask her name talk to her first about her family, her problem)*
- *Make her feel that you are focussing on her as a whole and not only on her reproductive tract*

**Maximum marks — 3**

**Name of the participant:**

**Name of the facility where working:**

**Date:**

[ **Note:** The questions included in the tool are taken from an exhaustive list of questions provided in the **Training Manual on Women's Health for Clinicians** published by the Women Centred Health Project. Trainers are advised to select questions and create their own test.]

Fact Sheet 2

# BUILDING A GENDER PERSPECTIVE

## Rationale

Over the last 30 years, several United Nations Conferences have drawn attention to women's needs. The Programme of Action of the 1994 International Conference on Population and Development (ICPD), Cairo, emphasised the need for a more women-centred approach to reproductive health and for extending reproductive health services beyond family planning. The ICPD also highlighted the importance of a life cycle approach to health. Apart from addressing the health needs of adolescent girls, it recommended that men must also be involved in health programmes. This would enable them to assume more responsibility not only for family planning but for their own sexual and reproductive behaviour, family income, children's education and the well-being of their partners and children. This idea was further reinforced during the Beijing Women's Conference in 1995. Gender equality and equity are to be recognised as ends in themselves and also as essential elements of sustainable development. United Nations conferences have also been asserting that violence against women must be eliminated.

This as well as a prior commitment to feminist principles, formed the background for WCHP's work on gender issues within the Public Health Department of MCGM. The effort was to sensitise health care providers and administrators in various cadres to gender issues relating to health and health care and to assist MCGM make the health system and services gender-sensitive.

## Activities

- Integration of gender and health in all training conducted for all levels of staff: clinicians, ANMs, MPWs and CHVs.
- Workshop on gender analysis for higher officials like DEHOs, AHOs and MOsH.
- A session on gender was included in the Integrated Skills Development

Training of the RCH Programme for all cadres of health care providers.

- The project worked with male health care providers to sensitise them to the concepts of sexuality, gender, and gender and health, mostly through workshops followed by meetings at regular intervals.
- The project built a knowledge base for further action through formative research about men's role in RH conditions and men's information needs.
- Stepping Stones and counselling training based on a gender perspective.
- The production of gender-sensitive IEC material.

## Achievements

- Health organisations in India have barely begun to grapple with the challenge of understanding gender and how health systems can be made more gender-aware and gender-sensitive. MCGM has gone beyond any other public health system in initiating a gender perspective in its work
- Health care providers analysed the public health system and the municipal health services from a gender perspective.
- The evaluation of the training workshop with senior officials showed that
- the training was thought-provoking and challenged participants' attitudes and practices;
- there was a high level of understanding of the concepts of gender and its effect on the health of individuals;
- participants felt that this workshop could and should result in making MCGM's health department more gender-sensitive and gender-just;
- they recommended similar workshops in the future not only to evaluate the implementation of gender-sensitive policies and programmes, but to also further and strengthen their own understanding of gender;
- The questionnaire used for evaluation of the workshop is presented in T-2.2
- A plan to integrate gender-related issues within the public health system was developed as a follow-up to the workshop (T-2.1).

## Constraints

- The plan for integrating gender issues in the public health system was not satisfactorily executed as no system to monitor its implementation had been developed.
- It was very difficult to identify suitable resource persons with some

experience of the public health delivery system for conducting gender and health workshops for male health workers.

## Recommendations

- Review of the implementation of the plan at the highest level to understand the difficulties in implementation.

### *Expected role of Senior Administrators*

- Commitment for implementing the plan at each level.
- Regular gender and health workshops for senior officers.

## List of Tools

T-2.1: Action Plan to Integrate Gender Issues within the Public Health Department

T-2.2: Workshop Evaluation Questionnaire for Gender Workshops.

# T-2.1

## Action Plan to Integrate Gender Issues Within the Public Health Department

| Activity | Responsibilities allocated in 1999 | Remarks Status as of September 2003 |
|---|---|---|
| 1. Posting of male–female MOs | DEHO (FW MCH) with Zonal DEHOs | Proposal put up by WCHP. Favourable action in some health posts and dispensaries. |
| 2. Timings | DEHO (FW MCH)<br>EHO + AMC, DMC | Issue needs to be discussed at the level of senior administrators. |
| 3. Male fertility clinics | SO (FW)<br>DEHO (FW MCH) | Could not be done. |
| 4. Privacy | AHO (Bureau)<br>MOH | Achieved through provision of curtains and reorganisation of physical structure. This was done by WCHP with support from respective MOsH in gynaecology clinics initiated by the project. |
| 5. Partner treatment | AHO (Training)<br>DEHO (FW MCH) | Sensitisation of health care providers from all cadres through Integrated Skills Development Training (ISDT) of the National Programme on Reproductive and Child Health (RCH). Partner notification emphasised in gynaecology clinics initiated by the project. |
| 6. ANM:MPW (4:2) | EHO<br>DEHO (FW MCH) | Filling up of vacant positions is a policy issue and requires discussion at senior administrative level. |
| 7. Emphasis on male methods | AHO (IEC)<br>AHO (Training)<br>AHO (Bureau)<br>Dr Ubale<br>DEHO (FW MCH) | The topic will be discussed in detail through the Special Skills Development Training (SSDT) of the National Programme on Reproductive and Child Health. The Municipal Corporation of Greater Mumbai has started a campaign for awareness generation on non-scalpel vasectomy (NSV). |
| 8. Sperm count facility | AHO (Training)<br>AHO (IEC)<br>Zonal DEHOs.<br>DEHO (FW MCH)<br>EHO | Vacant posts of laboratory technicians and laboratory assistants need to be filled. Privacy and safe environment for clients at the laboratory need to be ensured. |
| 9. Life cycle approach | AHO (Training)<br>Dr Ubale<br>DEHO (FW MCH) | Being covered through the Integrated Skills Development Training (ISDT) of the National Programme on Reproductive and Child Health (RCH). All cadres of health care providers have been sensitised to the concepts. |
| 10. Consent of women for MTP, TL | EHO<br>DEHO (FW MCH) | This issue was discussed in the ISDT of RCH. WCHP has been addressing this issue through counselling and contraceptive counselling sessions for the health care providers of the project wards. |
| 11. Awareness of decision-makers in the family | AHO (IEC)<br>DEHO (Cells) | Concept of gender and its relation to power is discussed in ISDT and through the Adolescent Girls Initiative. |



TOOL

| Activity | Responsibilities allocated in 1999 | Remarks Status as of September 2003 |
|---|---|---|
| 12. Integration of Health Post/ Dispensary | AHO (Training)<br>MOH<br>Dr Ubale<br>EHO<br>DEHO (FW MCH) | Proposal put up by Working Group. Review and discussion among the senior level administrators is essential for implementation of functional integration. |
| 13. Sex de-segregation of data on TB, Malaria, no. of beds occupied in hospitals | Sr SO<br>DEHO (Cells)<br>AHO (MIS) | Efforts were made by the project to revise the MIS formats. Since most of the formats are required by the state and central governments, revision of MIS is a very complex issue which the MCGM needs to take up with the state and central governments. |
| 14. Analysis of existing data from gender perspective | | Could not be done. |
| 15. Staggering timings | M.Os.H<br>DEHO(FW M CH)<br>EHO | This issue was repeatedly discussed with the administrators of the Public Health Department. A proposal to change the working hours of MPWs was also put up. Administrative issues need to be addressed for accomplishing the task. |
| 16. Posting near residence | DEHO (FW MCH)<br>DEHO (HQ)<br>Nursing Superintendent. | This is in practice. It is MCGM's standard policy to place, as far as possible, all outreach staff at health centres near to their place of residence. |
| 17. Crèches near railway stations (ward level) | AHO (Office)<br>AHO (Schools)<br>EHO | Could not be done. |
| 18. Sexual harassment | Law Officer<br>Dr Ubale<br>AHO (IEC)<br>DEHO (FW MCH) | WCHP initiated the process by organising meetings with MCGM and representatives of non-governmental organisations. Later on, the issue was taken up by the DMC (Education). A draft policy for addressing sexual harassment at the workplace has been developed. A circular has been sent for establishing complaints committees at ward level and at all big offices of the MCGM. All senior officers of MCGM have been sensitised to the issue of sexual harassment. A guideline for Complaints Committees to conduct enquiries has been developed. |
| 19. Appointment of male CHVs | AHO (Training)<br>M.Os.H, WCHP<br>DEHO (FW MCH) | Could not be done. |
| 20. Identifying male gender trainers | WCHP<br>AHO(Training) | Community Development Officers (CDOs) trained as key trainers for Stepping Stones, male multipurpose workers and CDOs from the project wards or members of the Men's Involvement Committee, and male key trainers for ISDT who are gynaecologists and paediatricians have been oriented to the concepts of gender, sex and sexuality, and patriarchy, as well as their effect on people's health in general and on reproductive health in particular. Some of these health care providers can be considered as gender trainers. |
| 21. More ladies toilets, sanitary bins | WCHP<br>AHO (Training) | Could not be done. |

| Activity | Responsibilities allocated in 1999 | Remarks Status as of September 2003 |
|---|---|---|
| 22. Gender issue to be incorporated in all trainings | AH.O (Training) WCHP. | 'Gender' as a topic was included in the in-service training conducted in 1999. The ISDT of RCH has a 90-minute session on gender and another 90-minute session on women's perspectives. Discussion on gender has been included in all sessions of ISDT. The project has discussed gender in all its trainings for CHVs, ANMs, MPWs, CDOs, Medical Officers and administrators. Senior administrators are regularly briefed about the need to incorporate gender into all training programmes planned by the training cells of MCGM. |

## T-2.2

# Workshop Evaluation Questionnaire for Gender Workshops

1. What are the three new things about gender that you learnt in this workshop?
2. What are the three new things about 'gender and health' that you learnt in this workshop?
3. What are the three things that you plan to change in (*a*) your personal life, and (*b*) in your work life?
4. What are your reactions to this workshop vis a vis its (*a*) content, and (*b*) logistic arrangements?
5. What do you suggest as a follow-up of this workshop?

Fact Sheet 3

# COUNSELLING TRAINING

## Rationale

Observations and exit interviews conducted in health posts and at the gynaecology outpatient department (OPD) of a peripheral hospital showed that client–provider communication was mainly one way. The social aspects of the health conditions of patients were not explored in depth and information about diagnosis, treatment and contraceptive choices was insufficiently provided. Internal investigations could also have been carried out in a more patient-friendly manner (detailed reports of the communication studies are available with the project). To meet the information and counselling needs of women seeking services for sexual and reproductive health conditions, the project initiated a counselling centre at the gynaecology OPD of V. N. Desai Hospital. To ensure the sustainability of this initiative beyond the duration of the project, it was proposed that auxiliary nurse midwives (ANMs) and multipurpose workers (MPWs) be trained in relevant skills. A four-day counselling training was organised for the ANMs and male MPWs to be posted at the counselling centre. The training aimed at building the communication and counselling skills of participants and refreshing their technical knowledge about medical termination of pregnancy, high-risk pregnancy and reproductive health problems among adolescent girls. It was hoped that this would empower the health care providers to counsel women seeking services at the gynaecology outpatient clinic at the hospital. An outline of this training workshop is presented in T-3.1. Training in counselling skills was followed up by training in counselling for family planning. The outline of this workshop is presented in T-3.2.

## Activities

- 100 episodes of client–provider communication were observed to identify gaps in communication and the unmet information needs of the clients.
- Findings were shared with the providers to arrive at a consensus that they would benefit from a refresher course in communication and counselling skills.
- Four-day workshops were conducted for three batches of health care providers (eight PHNs, 25 ANMs and 15 MPWs). Each participant was placed at the Counselling Centre for 15 days to gain practical experience.

- Client–provider communication was monitored and gaps in family planning counselling were identified.
- A workshop (two half-days) was conducted to sensitise providers to the clinical and social issues related to family planning.

## Achievements

- Health care providers readily acknowledged the need for improving information and counselling services to clients and their partners.
- The training provided them an opportunity to discuss differences in opinion about choice of contraceptives between providers and clients and differences in attitudes towards patients' rights between doctors and counsellors. Providers were sensitised to the social and rights aspects of reproductive health conditions.
- In addition to the training, the changed layout and the regular meetings of the entire staff of the gynaecology OPD about the quality of services provided worked well in establishing a culture that emphasises good communication between clients and providers.
- Observation of counselling being done by some of the ANMs, MPWs and PHNs during the end-evaluation and reports from supervisors showed good basic counselling skills that could be further improved through continued supervision. Self-reported changes indicated a perceived improvement in the counselling skills of ANMs and MPWs. They also stated that they could apply the training to RH as well as other conditions seen at the health posts or dispensaries.
- Counselling training has been incorporated in the Integrated Skills Development Training for the National Programme on Reproductive and Child Health for all cadres. Six hours are allotted for sessions on counselling during ISDT.

## Constraints

- All health workers do not have an aptitude for counselling. The training and 15 days of practical experience covered too short a period to provide these health workers with the required skills. Good client–provider communication is not emphasised in the Health Department. Rather, persuasion is used to meet departmental targets. To achieve a culture that emphasises good client–provider communication takes time and the full commitment of the organisation concerned. In this context, we need to make a distinction between basic counselling skills that all health workers need and the more complex counselling that calls for referral to specially trained counsellors.

- Due to limited human resources it was not possible to supervise all male participants during the 15-day period of practical training.
- Male multipurpose workers placed at the counselling centre lacked the skills to approach the male partners accompanying women to the gynaecology OPD and explain the availability of counselling and information services for men in relation to women's health.
- The involvement of multipurpose workers in counselling makes it possible to provide counselling and information to both couples and men. However, most multipurpose workers would need more intensive training to be able to also take women's perspectives into account. Only those who went through the gender and sexuality training were able to master the more complex skills and changed perspectives needed for successful couple counselling.
- Counselling training needs to be conducted at regular intervals. Since the hospital plays a limited role in the organisation of trainings, its sustainability remains a problem.

## Recommendations

- Continue exit interviews and observations of client–provider communication using the instruments developed by the project, as part of the RCH programme (see T-9.3). Feedback to providers about the outcomes and supervision of quality rather than quantity (targets reached) will be an important part of establishing a culture for good quality of client-provider communication throughout the Health Department.
- Training on its own is insufficient to achieve good client–provider communication. The client feedback box and regular team meetings on the quality of care provided were an important part of changing the culture of the outpatient department, and should be included in all interventions to improve counselling and client–provider communication.
- Only motivated ANMs, PHNs and MPWs should be posted to the counselling centre.
- Nurses from the outpatient clinic and the hospital can play a key role in providing information and counselling services to clients. They should be trained in counselling skills.
- Community Development Officers from peripheral hospitals could supervise the trainees during the period of practical training.

***Expected Role of Deputy Executive Health Officer in Charge of Training, IEC and MIS (DEHO-CELLS)***

- Training for building counselling skills for reproductive and sexual health conditions should be incorporated in the RCH training for all cadres.

***Expected Role of Assistant Health Officer in Charge of Training (AHO-Training)***

- Organising and coordinating counselling training for all cadres of health care providers.
- Forming a group of key trainers to conduct the training workshops.
- Establishing mechanisms to assess the efficacy of counselling training workshops.

***Expected Role of MOsH***

- Identifying health care providers with an aptitude for counselling from their respective wards.
- Providing administrative assistance to community development officers for organising and conducting counselling training.
- Ensuring that health care providers trained in counselling skills are posted at the counselling centre for a pre-determined duration.

**List of Tools**

T-3.1 : Outline of Counselling Workshop for Auxiliary Nurse Midwives, Male Multipurpose Workers and Public Health Nurses

T-3.2 : Outline of Workshop on Contraception Counselling for Medical Officers

T- 3.1

# Outline of Counselling Workshop for Auxiliary Nurse Midwives, Male Multipurpose Workers and Public Health Nurses

## Objectives

- To familiarise the participant health care providers to the principles of counselling and the skills required

## Outline of Counselling Workshop

| Session Topic | Contents | Time | Methodology |
|---|---|---|---|
| *Day 1* | | | |
| 1. Introductions | • Ice breaker exercises | 30 minutes | • Ice breakers and games |
| 2. Pre-test questionnaire | • Pre-test questionnaire | 30 minutes | • Questionnaire |
| 3. Gender and Health | • Gender and Sex<br>• Implications of gender in terms of power and decision-making framework<br>• Gender and health – RH | 120 minutes | • Pictures of gender stereotypes<br>• Lecture and discussion<br>• Gender analysis framework |
| 4. Sensitivity in counselling and qualities of a counsellor | • Qualities desirable in a counsellor | 60 minutes | • Exercise |
| 5. Self-realisation | • Self-evaluation for increasing openness, getting feedback and sensitivity | 30 minutes | • Questionnaire |
| 6. Communication skills | • Verbal and non-verbal communication<br>• Skills required for effective communication | 30 minutes | • Lecture<br>• Role play<br>• Discussion |
| 7. Errors in counselling | • Do's and don'ts in counselling in terms of principles and values | 20 minutes | • Role play<br>• Discussion<br>• Lecture |
| *Day 2* | | | |
| 8. Macro and micro skills in counselling | • Macro and micro skills in counselling | 75 minutes | • Lecture<br>• Role play<br>• Discussion<br>• Exercise for converting closed questions into open-ended ones |
| 9. High-risk ANC and hysterectomy | • Technical aspects of high-risk ANC and hysterectomy | 120 minutes | • Question– answer<br>Lecture |

| Session Topic | Contents | Time | Methodology |
|---|---|---|---|
| | • Gender and sexuality in the context of high=risk ANC and hysterectomy<br>• Men's role in ANC and hysterectomy | | |
| 10. Violence and health | • Concept of violence<br>• Violence as a health issue and its consequences<br>• Skills required for counselling of survivors of violence | 90 minutes | • Brainstorming<br>• Group work<br>• Presentation |
| 11. Sexuality and health | • Sexuality<br>• Relevance of discussing sexual issues in gynaecological UPD | 120 minutes | • Exercises on values and attitudes towards sexuality<br>• Discussion<br>• Presentation |
| 12. Information needs of clients | • Information needs of clients | 45 minutes | • Exercise |
| *Day 3* | | | |
| 13. Practical experience of working with clients visiting the gynaecology OPD | • Skills required by counsellors | 120 minutes | • Practical visits to various departments of hospital |
| 14. Effective use of IEC material in gynaecological counselling | • Importance of the use of IEC material in counselling | 90 minutes | • Group work<br>• Exercises<br>• Demonstration of condom use |
| 15. Demonstration of counselling skills | • Verbal, non-verbal, macro and micro skills | 60 minutes | • Role play<br>• Discussion |
| *Day 4* | | | |
| 16. MTP and contraception | • Technical aspects of MTP and contraception<br>• Importance of informed choice, reproductive rights<br>• Gender and sexuality issues relating to MTP and contraception | 120 minutes | • Question–answer<br>• Lecture |
| 17. Recording counselling cases | • Documentation of counselling cases | 30 minutes | • Practice session for filling in forms |
| 18. Practising counselling skills | • Demonstration of counselling skills by trainees | 120 minutes | • Role play |
| 19. Evaluation and post-test questionnaire | • Evaluation and post- test | 30 minutes | • Questionnaire |

T-3.2

# Outline of Workshop on Contraception Counselling for Clinicians

## Objectives

- To familiarise the participant clinicians with the principles of contraception counselling based on a rights' approach
- To discuss the barriers faced by clinicians in counselling women and identify ways to address these

## Outline of the Workshop on Contraception Counselling

| Session Topic | Contents | Time | Methodology |
|---|---|---|---|
| 1. Informed choice and women's reproductive rights | • Concepts of informed choice, reproductive health rights<br>• Quality of care framework for counselling<br>• Analysis of rights to identify areas difficult to implement and suggesting alternatives for implementation | 90 minutes | • Presentation<br>• Group work<br>• Presentations |
| 2. Current practices in family planning services in public health department | • Review of current practices in the context of women's human rights and reproductive rights | 90 minutes | • Role play<br>• Discussion |
| 3. Agreed principles of quality of care and reproductive rights | • Identifying practical ways of implementing concepts of quality of care and reproductive rights | 60 minutes | • Group work<br>• Presentation |

**Note:** Detailed report of the workshop is available with the project.

Fact Sheet 4

# CONTINUING MEDICAL EDUCATION

## Rationale

One shortcoming of the public health system in Mumbai is the lack of forums for refreshing knowledge of medical officers from primary level facilities. This is especially the case for doctors in charge of dispensaries. Participants in the clinicians' training on clinical and social aspects of selected reproductive conditions reported feeling excluded from the updates in the medical sciences. They also expressed that continuing medical education would improve the quality of reproductive health services.

The forum for Continuing Medical Education (CME) was initiated to meet this felt need of doctors for continuous interaction with their colleagues and experts after their training in four sexual and reproductive health conditions. Medical officers from health posts, dispensaries and maternity homes attended monthly meetings held by CME to discuss cases they had handled in their facility and receive guidance from the experts. Regular CME meetings coupled with monitoring visits by consultant gynaecologists ensured the quality gynaecological services were provided at the primary level.

## Activities

- CMEs were started in both the project wards in November 1998 on pilot basis. The doctors met once a month under the guidance of an honorary doctor of one maternity home and the MOi/c Maternity Home of the other ward.

**Functioning of CME**

- One day in a month was fixed for CMEs by the convenor and the participant medical officers.
- Each meeting lasted for three hours.
- The topic for discussion at the next session was decided at the end of each meeting.
- Efforts were made to ensure the active participation of all medical officers.
- Medical officers from primary level health care facilities (both health posts and dispensaries) presented cases on pre-determined topics.
- The convenor facilitated the discussion on cases and gave technical inputs.

In every CME, clinicians presented cases on a topic decided in previous the

CME. This was followed by a group discussion, with inputs being provided by experts.

The interest in improving their skills and concern for patients was reflected in their requests for information. For example, along with clinical topics, the doctors requested sessions on social issues. Concerned about couples with long-term fertility problems, they wanted information about the different options, including adoption, that they could advise the couples on. The doctors also requested sessions on violence against women and child abuse.

## Achievements

- All medical doctors actively participated in the CME sessions and reported that they had benefited from the discussions and the technical guidance offered.
- The sessions included discussions on social issues relating to medical conditions.
- The CMEs also served as a forum to discuss the problems faced by clinicians at the primary level, e.g., lack of privacy, non-functioning of equipment, etc., and ways of overcoming these. These problems were later discussed in the monthly ward meeting with the Medical Officer of Health (MOH).
- During the midterm evaluation, clinicians described CMEs as an informative as well as problem-solving forum.

## Constraints

- The success of CMEs depended largely on the motivation and skills of the convenor, and they had to be discontinued when the convenor was transferred to another ward.
- The high priority accorded to various national and ad hoc programmes affected the regularity of CMEs. Administrative support is therefore essential for sustaining the programme.

## Lessons Learnt

- The involvement of Medical Officers of Health (MOsH) in CMEs is important for sustainability.
- It is essential to have a skilled and dedicated convenor associated with the Municipal Corporation of Greater Mumbai to conduct CMEs. Guidance and motivation from experts contribute significantly to the sustainability of the initiative.

## Recommendations

- The Medical Officer in charge of the maternity home along with the Assistant

Health Officer (AHO)/Deputy Executive Health Officer (DEHO) should take the initiative for organising the meetings with an honorary doctor as convenor.

- CMEs should include gender the and social dimensions of clinical conditions in the discussions.
- They should be conducted at a regular interval (once a month) and cover all conditions treated at primary level.
- Teaching hospitals can help in conducting CMEs for medical officers along with practical training.
- CMEs should also be arranged for ANMs, male MPWs and public health nurses to refresh and update their clinical knowledge. Full-time Medical Officers of health posts should conduct sessions for CHVs to refresh and update their knowledge about the clinical and social aspects of reproductive health conditions. Outreach staff who are well-informed about the technical and social aspects of reproductive health conditions can play a key role in generating demand for reproductive health services.
- The quality of CMEs should be regularly monitored, perhaps by honorary doctors attached to the maternity home.

***Expectations from Deputy Executive Health Officers (DEHOs) / Assistant Health Officers (AHOs)***

- Incorporation of monthly CME into the National Programme on Reproductive and Child Health.
- Allocation of funds for conducting monthly CMEs. (Assuming 20 persons attend the CME, the total cost would be Rs 50 for tea + Rs 200 for honorarium if an external resource person is invited to conduct the CME session.)
- Technical supervision with the help of gynaecologists from post partum centres and teaching hospitals.
- Direct Medical Officer of Health (MOH) or Junior Medical Officer to attend the CMEs.

***Expectations from Medical Officers for Health (MOsH)***

- Attend or direct the Junior Medical Officer to attend the CMEs.
- Ensure monitoring of the quality of the sessions.

## *Contribution of Resources for CMEs*

| Resources contributed by MCGM | Resources contributed by the Project |
|---|---|
| • Venue<br>• Honorary gynaecologist of maternity home as convenor of the CME<br>• MO i/c PPC (gynaecologist) as resource person)<br>• Administrative assistance | • Coordination of the programme — issuing circulars for meetings for meetings<br>• Refreshments for participants<br>• Documentation of meetings<br>• TA to participants |

Fact Sheet 5

# WORKING WITH MEN ON REPRODUCTIVE HEALTH ISSUES

## Rationale

A specific objective of the Women Centred Health Project was to explore the role that men can play in preventing reproductive health conditions and supporting women suffering from such conditions. This fact sheet presents a review of activities undertaken by the project for involving men in women's reproductive health and recommendations for the future.

## Activities

Activities related to men's involvement could be grouped under:

1. Capacity building of health care providers to work with men.
2. Research with (*a*) clients and partners, and (*b*) service providers.

### 1. Capacity building of male multipurpose workers (MPWs) to work with men

- Workshops on Sexuality, Gender and Health to orient male MPWs to the concepts and to build up their perspective on these issues (T-5.2 and T-5.5).
- Formation of a Men's Involvement Committee (MIC) to brainstorm and identify the possible roles that MPWs can play in sensitising men to women's health needs.
- Training MPWs in group facilitation skills (T-5.3 and T-5.4).
- MPWs were trained in basic counselling skills and participated in Stepping Stones — a communication methodology for talking about sexuality and STI prevention in the community.

### 2. Research with (*a*) clients and partners, and (*b*) service providers

- Informal interviews with men and their partners to understand the role that men play in antenatal care, treatment for childlessness, medical termination of pregnancy (MTP) and contraceptive acceptance.
- Focus group discussions and interviews to explore information needs of men regarding reproductive health, specifically reproductive tract infections, medical termination of pregnancy, childlessness and antenatal care.
- Interviews with all cadres of health care providers at the health posts to explore how they could involve men in the reproductive health of women.

## Achievements

- Male health care providers recognised the need for involving men in reproductive health for meeting the health needs of both men and women.
- MPWs conducted interactive sessions on reproductive tract infections with adolescent boys and men in the community.
- Workshops on sexuality, gender and health enhanced the motivation levels of MPWs and convinced them of the importance of men's involvement in women's health. MPWs also claimed that the workshops were important for them at a personal level.
- MPWs trained in counselling skills started counselling men accompanying women to the gynaecology clinic at a secondary hospital.
- On their own initiative, a group of MPWs and male community development officers (CDOs) developed a training module on Family Life Education for adolescent boys. An outline of this module is presented in T-5.1. The pre-test used to explore the attitudes and knowledge of adolescent boys about sexual and reproductive health is presented in T-5.6.
- The Men's Involvement Committee formed by the project works as a forum for MPWs to brainstorm about strategies for increasing men's involvement in reproductive health and to review and comment on other activities of the project such as messages for men in the IEC material developed by the project.
- MPWs from wards other than the project wards expressed interest in working on this issue and voluntarily joined the Men's involvement Committee.

## Constraints

- Initial resistance from MPWs to the concept of gender posed problems in organising the workshops. MPWs felt that traditional power relations were being questioned and failed to see the linkages between gender and health and the need for men to be sensitised to this issue.
- Lack of knowledge about various sexual and reproductive health conditions and the relative young age of MWPs make them vulnerable to ridicule by older men in the community and influences their confidence levels in working with men.
- Women trainers conducting sessions on gender and sexuality were not acceptable to MPWs in the initial stages. They were labelled as 'pro-women' and 'non-sympathetic towards men'. Identifying male trainers acceptable to the MPWs was a difficult and time-consuming task.

- Transfers or promotions to departments other than Public Health Department forced MPWs to leave the group, thus affecting continuity.

## Lessons Learnt

- Establishing fora such as the Men's Involvement Committee is an effective strategy for motivating MPWs for discussion and implementation of various activities.
- Male health workers in the public health system are a valuable resource for working with men on issues of reproductive health.
- When provided with an opportunity and a platform to share their ideas about increasing men's involvement, the MPWs come up with concrete suggestions.

## Recommendations

- Male health care providers need regular inputs on technical as well as social topics to work with men in the context of reproductive health.
- RCH puts a strong emphasis on men's involvement in reproductive health. MPWs who have been sensitised to the issues of gender, sexuality and the social determinants of reproductive health conditions can serve as a crucial link between the public health services and the men from the community. MPWs' role in the implementation of RCH needs to be defined clearly, with feasible strategies worked out for involving men in women's RH.

## List of Tools

T-5.1 : Outline of Training Module on Reproductive and Sexual Health for Adolescent Boys

T-5.2 : List of Gender, Health and Sexuality Workshops conducted for Male Health Workers

T-5.3 : Outline of Facilitation Skills Workshops conducted for Male Health Workers

T-5.4 : Pre- and Post-Test Used for the Facilitation Skills Workshop for Male Health Workers

T-5.5 : Workshop Evaluation Format Used for the Gender and Health and Facilitation Workshop

T-5.6 : Pre- and Post-Test Used with Adolescent Boys to Explore Attitude and Knowledge

T-5.1

# Outline of Training Module on Reproductive and Sexual Health for Adolescent Boys

## Objectives

- To provide information on physical and emotional changes that occur during puberty in a participatory manner.
- To introduce adolescent boys to the concepts of gender and sexuality and how they affect boys and girls.
- To initiate discussion regarding men's responsibility in reproductive health.

**Total Duration:** 17 hours, 20 minutes (3 days)

**Module 1 – Growing Up: (Duration- 5 hours, 20 minutes)**

| | |
|---|---|
| ***Session–1*** | ***Anatomy, physiology and physiological changes during puberty*** |
| **Duration** | 60 minutes |
| **Expected outcome** | At the end of the session participants will<br>• gain knowledge about human body structure, differences in male–female bodies and physical changes during puberty |
| **Methodology** | Body mapping exercise, Discussion |
| ***Session – 2*** | ***Emotional changes during puberty and channelling the energy*** |
| **Duration** | 50 minutes |
| **Expected outcome** | At the end of the session participants will<br>• be aware of emotional changes that occur during puberty and accept them<br>• be aware of how these changes affect their behaviour towards self and others<br>• be able to suggest ways to channellise their energy constructively |
| **Methodology** | Case study followed by discussion |

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| | |
|---|---|
| ***Session – 3*** | ***What Is love?*** |
| **Duration** | 60 minutes |
| **Expected outcome** | At the end of the session participants will<br>• be able to analyse their perception of love<br>• understand that love is more than physical attraction<br>• realise that love involves responsible behaviour (physically and emotionally) from both partners |
| **Methodology** | Case study, Discussion |
| ***Session – 4*** | ***Gender and equality*** |
| **Duration** | 60 minutes |
| **Expected outcome** | At the end of the session participants will be able to<br>• understand the social construction of 'gender'<br>• understand how gender constructs decide division of labour between men and women<br>• realise the need to bring about 'equality' |
| **Methodology** | Exercise, Game, Discussion |
| ***Session – 5*** | ***Values regarding sexuality*** |
| **Duration** | 90 minutes |
| **Expected outcome** | At the end of the session participants will be able to<br>• reflect upon and clarify their values, beliefs and attitudes related to sex and sexuality<br>• realise that biased values and attitudes can lead to biased behaviour |
| **Methodology** | Agree/disagree statements followed by discussion |

**Module 2 – Health and Nutrition: (Duration – 3 hours, 30 minutes)**

| | |
|---|---|
| ***Session – 1*** | ***Importance of balanced diet*** |
| **Duration** | 60 minutes |
| **Expected outcome** | At the end of the session participants will be able to<br>• gain knowledge about nutrients in different kinds of food and what is a balanced diet<br>• explore diet-related myths, especially those arising from social/gender discrimination (e.g., women eat less as they are delicate) |

| | |
|---|---|
| **Methodology** | Game, Discussion, Poster presentation |
| ***Session – 2*** | ***Personal hygiene and habits affecting health*** |
| **Duration** | 60 minutes |
| **Expected outcome** | At the end of the session participants will be able to<br>• understand the importance of personal hygiene<br>• understand the ill effects of addictions on their health<br>• reflect on the reasons for addictions among adolescents and their own behaviour/habits |
| **Methodology** | Poster demonstration, Free listing, Small group discussions |
| ***Session – 6*** | ***Importance of games, exercise and recreation*** |
| **Duration** | 90 minutes |
| **Expected outcome** | At the end of the session participants will be able to<br>• learn and practise exercises for physical fitness<br>• experience the games that relieve stress<br>• realise the role of games and recreation in keeping away from addiction |
| **Methodology** | Games, Physical exercises, Free listing, Discussion |
| **Module 3 –** | **Reproductive health: (Duration – 4 hours 30 minutes)** |
| ***Session – 1*** | ***Reproductive organs and their functions*** |
| **Duration** | 60 minutes |
| **Expected outcome** | At the end of the session participants will be able to<br>• gain knowledge about reproductive organs and their functions |
| **Methodology** | Question-answer, Model demonstrations |
| ***Session – 2*** | ***Men's involvement in reproductive health*** |
| **Duration** | 60 minutes |
| **Expected outcome** | At the end of the session participants will be able to<br>• reflect on their role in the reproductive health of their partner<br>• suggest ways to be a responsible partner<br>• analyse their own reproductive health needs |
| **Methodology** | Agree/disagree statements followed by discussion |

| | |
|---|---|
| ***Session – 3*** | ***Sexual exploitation*** |
| **Duration** | 90 minutes |
| **Expected outcome** | At the end of the session participants will be able to<br>• share their personal experiences of exploitation<br>• discuss ways to prevent and protest sexual abuse of self and others |
| **Methodology** | Free listing, Documenting self-experience, Lecture, Discussion |
| ***Session – 4*** | ***STD – HIV/AIDS*** |
| **Duration** | 60 minutes |
| **Expected outcome** | At the end of the session participants will be able to<br>• gain knowledge about sources STD/HIV infection and ways to prevent it. |
| **Methodology** | Game, Poster demonstration, Question-answer |

**Module 4 – Self-awareness: (Duration – 4 Hours)**

| | |
|---|---|
| ***Session – 1*** | ***Who am I?*** |
| **Duration** | 60 minutes |
| **Expected outcome** | At the end of the session participants will be able to<br>• analyse their own strengths and weaknesses in the context of gender norms prevailing in the society<br>• explore ways to deal with pressures of prevailing gender norms<br>• understand the importance of accepting others with their strengths and weaknesses |
| **Methodology** | Exercise, Question-answer, Discussion |
| ***Session – 2*** | ***My values and skills development*** |
| **Duration** | 90 minutes |
| **Expected outcome** | At the end of the session participants will be able to<br>• understand the importance of clarifying values and how it can enhance behaviour<br>• be aware of the skills required to develop their own personality |
| **Methodology** | Story-telling, Free listing, Games, Discussion |

**Session – 3** ***Community participation***

**Duration** 90 minutes

**Expected outcome** At the end of the session participants will

- understand what is responsible behaviour as a citizen
- be aware of their potential to initiate change in the society
- identify issues on which they want to work within their community
- be able to suggest plan of action to bring change in the minds of people by way of awareness generation or through social functions.

**Methodology** Group work, Lecture, Presentations

[**Note** : The module is being modified after a peer review. It is available with the project.]

T-5.2

# List of Gender, Health and Sexuality Workshops Conducted for Male Health Workers

| Sr. No. | Name of Session | Resource Person |
|---|---|---|
| 1 | **Workshop on Sexuality**<br>(June 18 – 20, 2001)<br>• Sexual concerns of young men<br>• Physical change in women's body and sexual concerns<br>• Values relating to sexuality<br>• Male sexual dysfunction<br>• Female sexual dysfunction<br>• Family planning methods and clinical services<br>• Counselling situations<br>• Talking on sexuality with community men | Dr Vitthal Prabhu<br>Dr Manda Purandare<br>Dr Mahindra Watsa<br>Dr Janki Desai<br>Dr J.V. Bhatt<br>Dr Manisha Deshpande |
| 2 | **Workshop on Sexuality**<br>(September 6-8, 2001)<br>• Sexual concerns of young men<br>• Physical change in women's body and sexual concerns<br>• Values relating to sexuality<br>• Male sexual dysfunction<br>• Female sexual dysfunction<br>• Family planning methods and clinical services<br>• Counselling situations | Dr Vitthal Prabhu<br>Dr Manda Purandare<br>Dr Hitesh Shah<br>Dr Vinod Dua<br>Mr Pramod Nigudkar<br>Dr Kusum Zaveri<br>Mr Pramod Naik |
| 3 | **Workshop on Gender and Health**<br>(March 10-14, 2002)<br>• Understanding the sociocultural determinants of health<br>• Sex and gender<br>• Gender roles, access and control, understanding patriarchy<br>• Masculinity and health<br>• Gender-based violence<br>• Gender analysis of common health problems<br>• Commitment to change at individual and professional level<br>• Male involvement and participation<br>• Violence faced in personal life as a man<br>• Trying to change | Dr Abhijeet Das<br>Mr Satish Singh<br>(Sahyog, Lucknow) |
| 4 | **Workshop on Facilitation Skills**<br>(August 1-4, 2002)<br>• Adult learning<br>• Trust building<br>• Listening and IPC skills<br>• Theatre forum<br>• Counselling<br>• Use of IEC material<br>• Case history<br>• Group discussions | Mr Satish Singh<br>Mr Dinesh |

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| Sr. No. | Name of Session | Resource Person |
|---|---|---|
| 5 | **Workshop on Gender, Health and Facilitation Skill**<br>(December 17-20, 2002)<br>• Sex and gender<br>• Patriarchy<br>  ◆ Understanding the sociocultural determinants of health<br>• Use of different training methodologies<br>  ◆ Case study<br>  ◆ FGD<br>  ◆ Use of IEC material<br>  ◆ Role play<br>• Basic human rights and reproductive rights | Mr Satish Singh<br>Dr Dinesh |
| 6 | **Workshop on Theatre Forum**<br>(December 21, 2002)<br>• Evolution of theatre forum<br>• Use of this technique in street play for awareness generation | Dr.Dinesh |

T-5.3

# Outline of Workshop on Facilitation Skills for Male Health Workers

## Objectives

- To build the capacity of MPWs in terms of perspective and skills for group facilitation

| Session Topic | Contents | Methodology |
|---|---|---|
| **Day – 1** | | |
| • Introduction | • Introduction of the participants | • Participants were asked to say their name and identify themselves: 'Who am I?'. And tell a joke |
| • Game | • Importance of games and songs in participatory training<br>• Use of games in participatory training | • Demonstration followed by discussion |
| • Setting the context | • Exploring difficulties in terms of skills and knowledge faced by MPWs as 'individuals' exploring internal environment | • Small group discussion on case studies |
| • Information and awareness | • Difference between information and awareness<br>• Skills required for awareness generation | • Discussion |
| • Gender and patriarchy | • Patriarchy and its effects on various members of society Patriarchy and gender | • Discussion on Hindi feature film *'Astitva'* - presence/existence |
| **Day – 2** | | |
| • Participatory approach | • What is participatory approach?<br>• Participatory approach and adult learning<br>• Difference between participatory research and conventional research | • Small group discussions on case studies followed by presentation and discussion in large group. |
| • Adult learning | • Principles of adult education<br>• One-way and two-way communication<br>• Importance of two-way communication in adult learning<br>• Importance of participatory training methods in adult learning | • Exercise followed by lecture and discussion |
| • Trust | • Importance of trust in community-based activities<br>• Trust and adult learning | • Exercises followed by discussion |
| • Self awareness | • Importance of self-awareness and self-esteem in dealing with community<br>• Others can help us know better | • Johari window |

| Session Topic | Contents | Methodology |
|---|---|---|
| • Movie followed by group discussion | • Power relations | • Viewing of Hindi feature film -followed by discussion |
| Day – 3 | | |
| • IPC | • Listening skills<br>• Principles of communication | • Exercise followed by discussion |
| • Group Discussion | • Group discussion as a methodology – merits and demerits<br>• Skills for facilitating group discussion | • Exercise followed by discussion |
| • Feedback | • Importance of feedback<br>• Points to be remembered while giving feedback — skills<br>• Receiving feedback | • Demonstration<br>• Discussion |
| Day – 4 | | |
| • Essentials of counselling | • Basic principles of counselling | • Role play followed by discussion |
| • Use of IEC material — flash cards, case studies, role play | • Importance of interactive IEC material for adult learning<br>• Skills required for use of interactive IEC material | Exercise<br>• Feedback |
| • Theatre forum and practice<br>• Skills required for theatre forum | • Principles of participatory role play — theatre forum | • Exercise<br>• Practice<br>• Discussion |
| • Developing a self-development plan | • What do I need to improve in myself?<br>• Whose help can I take for this? | • Exercise |
| • Workshop evaluation | • Questions based on knowledge and attitude | • Pre-developed evaluation questionnaires |

T-5.4

# Pre- and Post-Test Used for Facilitation Skills Workshop for Male Health Workers

**Q.1 Mark the right answer**

1 For group discussion session there should not be more than 15 participants in one group. Agree/Disagree

***Expected answer: Agree***

2 For an interview or a group discussion, it is essential to take consent from participant/s. Agree/Disagree

***Expected answer: Agree***

3 It is necessary for an interviewer to maintain eye contact while asking question to an interviewee. Agree/Disagree

***Expected answer: Agree***

4 For an effective group discussion facilitator should have knowledge of local language. Agree/Disagree

***Expected answer: Agree***

5 Counsellor needs to show sympathy while counselling the client. Agree/Disagree

***Expected answer: Disagree***

6 For a health worker, knowledge of the relevant subject/s is sufficient for imparting health education. Agree-/ Disagree

***Expected answer: Disagree***

7 If a participant is feeling shy to talk in a group discussion, facilitator must compel him to talk. Agree/Disagree

***Expected answer: Disagree***

8 Facilitator should take notes during group discussion. Agree/Disagree

***Expected answer: Disagree***

9 At the end of an interview or a group discussion session, it is important to summarise the topics discussed during the interview or the group discussion session. Agree/Disagree

***Expected answer: Agree***

10 After every programme or group session, the facilitator should do self-evaluation. Agree/Disagree

***Expected answer: Agree***

**Q.2 Answer the following questions**

1. State five important issues that you would discuss with a person who has come to you with the problem of infertility.

***Expected answer:***

- Feelings about the problem
- Natural process of conception
- Sexual relations
- Conflicts it any
- Probable causes and investigations

2. A health education session is organised for men in your community. What would you do to get more male participants? (Write 5 things)

***Expected answer:***

- Street play
- Contacting local clubs
- Displaying notices at prominent places
- Organising activity that is of interest to men from community

3. What skills are required for an interview or group discussion?

***Expected answer:***

- Listening
- Paraphrasing
- Probing
- Use of humour
- Clarity of purpose
- Reflecting
- Communication skills, eye contact

4. What preparation is needed to conduct group discussions?

***Expected answer:***

- Space
- Inform about venue and timing to all participants
- Seating arrangement
- Checklist or guideline for group discussion
- Co-facilitator or recorder

**Q.3 Write in brief**

1. Why are 'communication skills' necessary for MPWs? When are these used during work?

***Expected answer:***

- MPWs are the only male outreach workers. Job chart of MPW includes contacting men and boys from the community to convey health information and to generate awareness about health issues and services provided through health posts. Communication skills such as listening skills, maintaining eye contact, clarity of thought and theatre skills are useful in reaching out to people, conducting health education sessions and for interpersonal communication.

2. Examples of non-verbal communication.

***Expected answer:***

- Nodding
- Hand movements
- Expressions on face
- Sitting style

3. How should your work in the community be evaluated?

***Expected answer:***

- Group discussions or interviews with men and women in the community to assess the reach and impact of activities carried out by health care providers.

4. What topics will you cover in a health education session for adolescent boys in your community?

***Expected answer:***

- Self-development
- Career
- Nutrition
- Gender
- Impact of media

T-5.5

## Workshop Evaluation Format Used for the Gender and Health and Facilitation Workshop

1 Was the objective of this workshop fulfilled? (Rate on the scale of 1–10)

2 What are the three main learning of this workshop?

3 In your opinion, how will this workshop help you be a 'good service provider'?

4 What changes do you want to bring in your personal and professional behaviour?

5 What form of help do you need to implement what you have learnt in this workshop?

6 In your opinion, what changes are required to make this workshop more effective?

7 In your opinion, should such workshops be organised on regular basis? Give reasons?

8 Feedback to trainers.

T-5.6

## Pre-and Post- Test Used with Adolescent Boys to Explore Attitude and Knowledge

**Mark the right answer**

1. It is important for girls to be beautiful. Agree/Disagree

   ***Expected answer: Disagree***

2. It is all right for boys to wear earrings. Agree/Disagree

   ***Expected answer: Agree***

3. Men are not timid. Agree/Disagree

   ***Expected answer: Disagree***

4. It is only men's responsibility to earn for the household. Agree/Disagree

   ***Expected answer: Disagree***

5. It is all right for a boy to ask dowry it he earns well. Agree/Disagree

   ***Expected answer: Disagree***

6. Girls cannot make decisions about their own lives and about other domestic matters. Agree/Disagree

   ***Expected answer: Disagree***

7. For boys it is a sign of masculinity to have sexual relations with more than one woman. Agree/Disagree

   ***Expected answer: Disagree***

8. It is important to be strong to be recognised as a 'man'. Agree/Disagree

   ***Expected answer: Disagree***

9. A boy who cannot propose to a girl is not a 'man'. Agree/Disagree

   ***Expected answer: Disagree***

10. Wife should be loyal to husband but it is okay if the husband is not. Agree/Disagree

    ***Expected answer: Disagree***

11. Masturbation leads to weakness. Agree/Disagree

    ***Expected answer: Disagree***

12. Women do not masturbate. Agree/Disagree

    ***Expected answer: Disagree***

13. Only semen is required for conception. Agree/Disagree

***Expected answer: Disagree***

14. Menstrual blood comes out from the same opening as urine. Agree/Disagree

***Expected answer: Disagree***

15. Menstrual blood is impure. Agree/Disagree

***Expected answer: Disagree***

16. Male relatives also sexually abuse girls. Agree/Disagree

***Expected answer: Agree***

17. It is wrong for a girl to have pre-marital sexual relations but not for a boy. Agree/Disagree

***Expected answer: Disagree***

18. Boys can be sexually abused too. Agree/Disagree

***Expected answer: Agree***

19. Homosexuality is unnatural. Agree/Disagree

***Expected answer: Disagree***

20. Only men can have homosexual relationships. Agree/Disagree

***Expected answer: Disagree***

21. Men can be raped. Agree/Disagree

***Expected answer: Agree***

22. To save themselves from sexual abuse, the women should stay at home. Agree/Disagree

***Expected answer: Disagree***

23. Girls who wear modern cloths are more likely to be raped. Agree/Disagree

***Expected answer: Disagree***

24. Modern clothes worn by girls excite boys and encourages eve-teasing. Agree/Disagree

***Expected answer: Disagree***

25. Girls should have restricted mobility for their own safety. Agree/Disagree

***Expected answer: Disagree***

26. Most of the HIV affected women are commercial sex workers. Agree/Disagree

***Expected answer: Disagree***

27. Blue films and pornography spoil/morally corrupt boys. Agree/Disagree

***Expected answer: Disagree***

28. When a woman says 'no' for sex, she actually means 'yes'. Agree/Disagree

***Expected answer: Disagree***

29. Cu-T is an oral tablet. Agree/Disagree

***Expected answer: Disagree***

30. *Nirodh* is 100% successful in prevention of transmission of HIV/AIDS. Agree/Disagree

***Expected answer: Disagree***

31. Reproductive Tract Infections and AIDS spread through sexual relations only. Agree/Disagree

***Expected answer: Disagree***

32. Only women should use contraceptives. Agree/Disagree

***Expected answer: Disagree***

33. It is not important for boys to know about contraceptives. Agree/Disagree

***Expected answer: Disagree***

34. Men cannot enjoy sex if they use a condom. Agree/Disagree

***Expected answer: Disagree***

Fact Sheet 6

# QUALITY ASSURANCE

## Rationale

The International Conference on Population Development (ICPD), 1994 was a milestone in the history of family planning–family welfare–maternal and child health programmes. It widened the scope from population control to reproductive health, introduced concepts of clients' rights, a client-centred approach and gender in the national programmes for family planning–maternal and child health. With this, the focus of MIS for national programmes needs to change from purely quantitative to a mix of qualitative and quantitative and gender desegregated indicators. A signatory to the ICPD Plan of Action, India introduced the National Programme for Reproductive and Child Health which is in keeping with the ICPD guidelines, and lays a strong emphasis on quality of care.

Women interviewed during the PID study conducted in Mumbai expressed dissatisfaction with the health care provided by MCGM's Public Health Department. At times the services provided at the primary level were rated as being of lower quality than those provided by large municipal hospitals and private practitioners. This prompted WCHP to explore the causes of women's dissatisfaction and work towards improving the quality of care available at MCGM's primary level health care facilities. The focus was on improving the quality of reproductive health services provided by MCGM health posts and dispensaries. Three baseline studies were conducted to understand the pre-intervention status of the health care system (Annex 6.1).

In order to meet the goal of 'quality' reproductive health care, the project focused on translating the gender component of 'quality assurance' into practice. The project's efforts therefore were oriented towards sensitising the health care providers to the concepts of quality of care, quality assurance, gender and health, and clients' rights. Health care providers were expected to apply these while implementing service delivery interventions — such as gynaecology clinics at health posts and dispensaries — introduced by the project.

'Quality of health care' It is concerned with **fully meeting the needs** of those who need the service most, at the **lowest cost** to the organisation, **within limits** set by higher authorities. It does not mean sophisticated or exclusive care.

Quality of care has three dimensions:

- Clients' perspective : What do the clients expect from health services?
- Professionals' perspective : Do services follow health care providers' professional standards?
- Management's (administrators')perspective : Are the resources being used productively? Are the services efficient?

'**Quality Assurance**' is a systematic way of ensuring and maintaining 'quality' of services and has proved useful globally. The process of Quality Assurance involves three major steps

1. Realising and acknowledging the problem
2. Planning an intervention and its implementation
3. Reviewing the outcomes of the intervention

If the desired outcome is not achieved, the process is repeated, thus making it a cyclical and continuous one.

## Activities

- WCHP has attempted to introduce MCGM staff from the two project wards to the concepts of 'quality of health care' and 'quality assurance' through a series of six workshops conducted over a period of four years (see Table 1 for details of workshops and their outcomes.)
- Sessions on the principles of quality assurance were incorporated into the Integrated Skill Development Training of the Reproductive and Child Health programme for all cadres of health care providers.

## Table 1: Outcomes of the Quality Assurance Workshops

| Workshop | Outcomes of the Workshop |
|---|---|
| **1st Quality Assurance Workshop (February 1997)** | • Identified strengths and weaknesses of the existing system. Three baseline studies followed the workshop.<br>  • Patient satisfaction study.<br>  • Providers' perspective about women's reproductive health.<br>  • Facility study. |
| **2nd Quality Assurance Workshop (January 1998)** | • Findings of the baseline studies were reviewed.<br>• Three areas — referral, communication and drug monitoring — were prioritised for intervention. Intervention studies were planned on pilot basis.<br>• Tools were developed. |
| **3rd Quality Assurance Workshop (April 1998)** | • Results of the pilot studies, carried out using the tools developed during the second QA workshop, were reviewed.<br>• Tools were finalised after incorporating the suggestions. |
| **4th Quality Assurance Workshop (February 1999)** | • Progress of the three interventions — referral, communication and drug monitoring — was reviewed.<br>• Achievements over a period of 10 months were assessed. |
| **5th Quality Assurance Workshop (November 1999)** | • This workshop assessed the progress in terms of 'quality assurance'.<br>• Issues, other than the three identified earlier, affecting quality of care were discussed, e.g., staff shortage, delays in getting maintenance and repairs done, etc.<br>• Issues that could be managed within available resources were identified, e.g., cleanliness, coordination between facilities under one roof, etc. Checklists were developed for these issues, example the cleanliness checklist presented in T-6.1<br>• Process for attaining the goal and tools for measurement of the progress were planned. |
| **Meeting with external resource persons ( November 2000)** | • Proposed formation of Working Group and Support Group and development of Patients' Charter as a strategy for introduction of concepts of Quality Assurance into Public Health Department |
| **6th Quality Assurance Workshop (April 2001)** | • Senior officers who are members of the Working Group proposed that a Patients' Charter and Quality Assurance Policy should be in place.<br>• It was decided that the Working and Support Groups will take up issues such as complaints redressal mechanisms, quality control cell, rating system, and implementation of the Patients' Charter. |
| **Convergence workshop (September 2001)** | • Issues like vacancies, shortage of essential drugs and user fees need to be followed up with the Municipal Commissioner.<br>• Functional integration of health posts and dispensaries to develop a health centre on the lines of the PHC in rural areas and streamlining MIS to eliminate tedious and repetitive reporting systems were identified as priorities and small groups were formed to address these issues. |

## Achievements

- Staff members from all the cadres worked together to identify and address the problems affecting the quality of health care provided at primary level facilities. After the fourth quality assurance workshop, a Core Committee with representation from both experimental wards was formed. The committee played a key role in organising the fifth workshop. This reflects willingness and commitment on the part of the system to adapt itself for the betterment of services
- A Working Group and Support Group for Quality Assurance were formed to spearhead the process of institutionalising quality assurance into MCGM's Public Health Department.This was the first step towards ensuring commitment from the middle and senior managers towards quality assurance processes.
- The Support and Working Groups acknowledged patients' rights and developed a 'Patients' Charter of Rights and Responsibilities'. This is the first initiative taken by any public health system for developing a patients' charter. The draft is ready and awaits permission from appropriate authorities for implementation throughout MCGM (T-6.2). Probable implications of implementing such a charter for MCGM are presented in Annex 6.3.
- The Support Group acknowledged the need for appreciation in maintaining staff morale. It developed a 'Ranking System' — a tool for reviewing the services provided by health care facilities — and proposed that it be implemented in all health care facilities and the facilities with maximum scores be accredited. The value of the tool lies in the fact that it attempts to build team spirit among the health care staff (T-6.3).
- Lack of functional integration of health posts and dispensaries emerged as an important factor affecting quality of care provided through MCGM's Public Health Department. The participants of the Convergence Workshop (Annex 6.2) felt the need to prioritise the issue and formed a small group to work out the implications and job descriptions for integrated health care facilities. The group broke up before it could complete the task.
- The project has been trying to get the Management Information System (MIS) modified ever since its inception. At the Convergence Workshop health care providers identified the revision of MIS (to make it easier to fill in) as a priority. They suggested using a comprehensive family card

in place of the multiple registers used for recording information and revising the reporting formats to eliminate repetition. The suggestions that emerged from the workshop were to be presented to competent authorities for approval and further action. However, this group too broke up before concrete steps could be taken.

## Constraints

- In the earlier phases of the project's activities, senior-most MCGM officials and policy-makers were not oriented in the process of 'quality assurance'. Once they were involved, the quality assurance activities obtained greater guidance and support.
- Translation of knowledge into practice has been difficult — the hierarchical structure of the MCGM does not provide an environment that is conducive for doctors at the health post or dispensary level to take any initiative.
- Inadequate documentation of earlier efforts within MCGM to improve the quality of services hampers the systematic study of quality assurance to learn from earlier initiatives.
- The Support and Working Groups and other small groups formed to work on functional integration and MIS could not be sustained. This proved to be a setback. It also means that the Patients' Charter of Rights and Responsibilities, the ranking system and other efforts initiated by these groups with middle and senior administrators will not be owned by the system and carried forward in MCGM.
- The experience of WCHP shows that commitment (in principle) by the administrators in absence of material resources fails to change practices at the grassroots level.

## Lessons Learnt

- With appropriate technical inputs and administrative support, grassroots level health care providers can analyse the health care delivery system and come up with viable suggestions for improving quality of care.
- Small groups of health care providers and administrators are excellent resources for brainstorming innovative ideas and for developing relevant interventions.
- The Patients' Charter of Rights and Responsibilities can prove to be a critical tool for
  - promoting accountability and transparency of the system;

- generating demand for services;
- promoting the clients' perspective on quality of care;
- promoting the gender aspect of quality of care.

## Recommendations

- More workshops are needed with senior MCGM officials to generate ownership and support towards the process of quality assurance.
- Strategies need to be identified to enable the smooth functioning of small groups such as the Support and Working Groups within the highly hierarchical structure of MCGM.
- Ways of overcoming obstacles at policy level (e.g., resource constraints) and issue of non-priority of quality of care need to be explored.

***Expectation from Deputy Executive Health Officers (DEHOs) and Assistant Health Officers(AHOs)***

- Review the quality assurance process worked out till date, offer feasible suggestions for wider implementation. Explore and suggest ways for sustaining small groups.
- Implement Patients' Charter of Rights and Responsibilities
- Implement minimum quality assurance package as mandatory under the RCH Programme and set up a QA Committee at the highest level.
- Ensure implementation of the selected QA measures at primary level facilities by addressing the constraints.
- Identify or develop tools for routine monitoring of quality of care.

***Expectation from Medical Officers of Health (MOsH)***

- Incorporate review of quality assurance measures into routine supervision.
- Monitor quality of care using various tools (developed at the 5th Quality Assurance Workshop) and review it in the monthly meetings.
- Delegate activities — for example, monitoring IEC activities, and activities relating to client satisfaction could be looked after by the community development officers (CDOs) at the ward level.
- Arrange training programmes or meetings for all cadres of staff departmentally and/or inter-departmentally to create awareness about problems.
- Set up ward-level QA committees.
- Review the number of patients referred from each facility to the referral centre and the problems encountered at the referral centre.

- Ensure regular assessment of quality of care and address the emerging issues.

**List of Annexes**

Annex 6.1 : Brief Findings of Baseline Studies
Annex 6.2 : Summary of Convergence Workshop
Annex 6.3 : Probable implications of implementing the Patients' Charter for the Municipal Corporation of Greater Mumbai

**List of Tools**

T-6.1 : Cleanliness Checklist for Municipal Health Care Facilities
T-6.2 : Patients' Charter of Rights and Responsibilities
T-6.3 : Proposed Criteria for Ranking Primary Level Health Care Facilities.

Annex 6.1

# Brief Findings of Baseline Studies

**Baseline Study 1 Patient Satisfaction Study**

***(a) Focus group discussion (4 groups)***

- MCGM services are used for inpatient care and in cases of emergency; private practitioners are preferred for minor ailments.
- Reasons for preferring private practitioners are: physical accessibility, convenient timings, reputation, better rapport, negative experiences with the municipal services.
- Negative experiences include non-availability of drugs and investigation facilities, overcrowding resulting in very little time spent with patient, long waiting time, rude staff behaviour.
- People were aware of MCGM's family planning and immunisation services but had inadequate awareness about the curative services provided by dispensaries.

***(b) Exit interview (367 users)***

- 75-89% respondents expressed satisfaction with doctors' services. More than 90% reported willingness for continuing treatment at the same facility. When asked, the reasons given for continuing treatment were 'good doctor' or 'good treatment' (31%), free services (22%) and near residence (18%).
- 78% of the female users expressed satisfaction about privacy during physical examination. However, the interviewers themselves noted a lack of privacy (in objective terms). This contradiction allows the inference that 'expectations' and 'satisfaction' are highly influenced by earlier experiences of the individual.
- More than three-fourths of the users (77%) did not ask the doctor any questions. However, only 8% of these users gave reasons for not asking questions or clarifying doubts. The reasons can be grouped under impolite behaviour of the doctor, crowded OPD, no time and shyness experienced by women patients to ask a male doctor any question.

**Baseline Study 2.** **Providers' perspective about quality of care :** *Focus group discussions (3 groups) and Survey (n=78)*

**Table 1 : Providers' perspectives on 'Quality of Care'**

| Constituents of 'good health care' | Respondents n=70 (%) |
|---|---|
| Adequate quantity of drugs | 26 |
| Patient satisfaction | 23 |
| Proper examination | 20 |
| All services available under one roof | 19 |
| Good staff behaviour | 17 |
| Quick services | 11 |
| Competent doctor | 9 |
| Good quality medicines | 4 |
| Others | 17 |

***Note:** Multiple responses.*

**Baseline Study 3** **Facility study**

Information about 12 health posts, 9 dispensaries and 2 post partum centres was gathered using a structured format.

***Findings***

- Inadequate space, overcrowding, lack of appropriate waiting area for patients.
- Shortage of staff, medical supplies and equipment were reported to affect quality of health care.

Annex 6.2

# Summary of Convergence Workshop

## Background

The need for revising the timetable of health care facilities to improving quality of care had been often discussed on various earlier occasions. A two-day workshop was organised on 6–7 September 2001 to brainstorm on the possibilities of revising the time schedule and for developing a framework for the same. Representatives of all cadres of health care providers from the Public Health Department participated in the workshop.

Dr. Thanekar, DEHO (AIDS), stated that the objective of this workshop was to offer practical, feasible suggestions for streamlining various activities carried out through the health posts and for ensuring time management for improving quality of care.

A meeting was conducted on 30 August 2001 to acquaint participants with the background for the workshop. The participants were also asked to be prepared for contributing to the workshop.

## The Workshop

On the first day of the workshop, the current activities for each cadre were presented to identify areas that needed to be changed. On the second day, the participants presented suggestions for implementing the changes.

## Salient Points from Presentations

- The presentations indicated that all cadres participate in all the programmes and activities but did not elaborate on the specific role of each cadre in these activities.
- At present, health posts and dispensaries have independent identities. This has certain benefits. However, integration of health posts and dispensaries is essential for streamlining health care services.
- Representatives of all cadres expressed lack of job satisfaction.
- Tasks relating to record-keeping were reported to consume more of the health workers time than service delivery. Health workers expressed the need for policy decisions to modify and simplify procedures.

On the second day, the participants were divided into six groups. Two groups worked on improvements in MIS formats, two groups on steps required for the functional integration of health posts and dispensaries located in the same premises, while one group each developed a daily and long-term timetable for stand-alone health posts and dispensaries. The main points from the presentations made by the different groups are presented below.

## Group 1: Stand-Alone Dispensary

- Developing timetable for dispensaries as per directions in the Reproductive and Child Health Programme.
- Emphasis on convenience to clients.
- Revision of job description of pharmacists — pharmacists to be trained in dispensing DOTS. Following training, they would assist the medical officers with DOTS. They could also help in IEC activities, taking blood smears and keeping the temperature records of patients with fever.

## Group 2: Stand-Alone Health Posts

- Full-time Medical Officers will conduct OPD throughout the day for three days of the week. This will ensure convenience of the clients.
- Growth monitoring will be carried out concurrently with immunisation.
- Family Health Cards should be prepared.

## Group 3: Integration of Health Posts and Dispensaries

- Integration could be one way of getting around the restriction on filling of vacant posts due to the financial constraints faced by MCGM.
- Integration of health posts and dispensaries to form a health care unit along the lines of Primary Health Centres in rural areas.
- Revision of job description for pharmacists. Common indent to be placed for the entire ward.
- If the integrated health post and dispensary have both a female attendant (ayabai) and labour, one of them could be reallocated to the health post or dispensary where these posts are vacant.
- Each ward should start one integrated health centre on a pilot basis.
- The feasibility of establishing integrated health centre in Mumbai was discussed. Participants had mixed feelings about this.

### Group 4: Integration of Health Posts and Dispensaries

- Full-time Medical Officers and Medical Officers in charge of Dispensary should assist in each other's work.
- In addition to submitting indent for dispensaries, pharmacists should look after the indenting of health posts.
- If possible, pharmacists should be trained in DOTS so they could help whenever they are not dispensing medicines.
- Each integrated centre would have two doctors, one of whom would be present in the centre throughout the day. This will ensure that patients do not have to return without consulting the doctor, which in turn will help improve the image of MCGM's health care facilities.

### Group 5: Revision of MIS

- MIS formats should be revised to eliminate repetition. Arrangements should be made to allow submission of all reports at one place.
- Subject-wise registers should be maintained. These registers should allow for recording by all ANMs and MPWs. ANMs and MPWs should share the responsibility of maintaining the registers.
- MCGM should ask for quarterly rather than bimonthly ones. Reports should cover changes from the time the last report was sent.
- Team spirit is important.



### Group 6: Revision of MIS

- Modifications suggested for reporting formats for FW & MCH.
- A format for complaint letters was developed for informing departments other than the health department about issues having implication for health. It was suggested that this complaint letter should be submitted to the complaint officer of each ward.
- A Family Health Card should be developed and used instead of follow-up registers.

### Issues Emerging from Discussion following the Presentations

- Responding to the point that 'pharmacists be trained in health education', Dr Kewalramani, AHO (IEC) emphasised that health education should not be regarded as a separate activity but as an integral part of all activities. Health education is an integral part of the work of all health

workers. Health workers must regard each contact with client or community as an opportunity for providing health education. Evaluation of health education should not be based on the number of health talks or group meetings conducted, but on the impact it has had on the clients or community.

- Some participants were of the opinion that role of MPWs was unclear in the daily/routine timetable of stand-alone health posts.
- Discussion on integration of health posts and dispensaries, especially in slum areas, received mixed feedback. Some participants felt that that the emphasis should be on increasing utilisation of dispensaries when health posts and dispensaries are located under the same roof.
- Transition of morbidity from infectious to chronic conditions will influence the nature of health care services. It will mean that more personnel will be required to provide long term support for chronic conditions and for prevention of such conditions. Outreach services for providing health information and for creating awareness among the community will play a key role in this situation. This must be considered while revising health care services. Responding to the changing health care needs is the responsibility of the MCGM. Hence increasing posts of medical officers cannot be a solution for improving quality of care. Integration of health posts and dispensaries seems to be the only feasible alternative at present. The presence of two medical officers will ensure that the services of at least one medical officer are available throughout the day. This will help increase client satisfaction.
- The importance of effective IEC and participation by NGOs, CBOs and the community in activities undertaken by the health posts and dispensaries was emphasised.
- Participants and senior officers stressed the need for conscious efforts to improve the image of MCGM.



## Future Plans

- A group will be formed to review and implement modifications suggested in the workshop. This group will meet regularly and follow up with the policy-makers.
- A group will be formed to review recommendations regarding integration of health posts and dispensaries. This group will work on this issue along with the Support Group and Working Group for mainstreaming quality assurance in MCGM's Public Health Department.

Annex 6.3

# Probable Implications of Implementing the Patients' Charter for the Municipal Corporation of Greater Mumbai

Following is the compilation of issues related to implementation of Patients' Charter of Rights and Responsibilities discussed in the meetings of Working Group. Most of the points presented here have been agreed by the members of this group. Issues where the discussion was inconclusive or when technical aspects were involved were deferred till discussion with experts concerned.

## 1. RIGHT TO INFORMATION ABOUT HEALTH SERVICES/BEST USE OF SERVICES

***RIGHT TO INFORMATION***

- Where are the municipal health services located?
- What are the timings?
- What are the services, both preventive and curative, provided through these centres?
- What are the fees for these services?
- Who can avail services provided through these facilities?

***HOW TO MAKE BEST USE OF SERVICES***

- Who can avail these services?
- When are they available?
- Which level of health care should be approached for what condition?
- Information about referral system (Will I be referred to a higher facility if I need specialty care? Which institute will I be referred to?)

**IMPLICATIONS FOR BMC**

- Information regarding services available, timings, fees, staff availability and availability of medicines should be displayed prominently on the board which should be placed such that it is visible to the community and patients.
- Boards indicating the name and address of the dispensary/health post/ hospital/municipal maternity home should be clear and visible
- CHVs should inform the community regarding services available through health posts, dispensaries, maternity homes and secondary hospitals

- Outreach staff (CHVs, ANMs, MPWs, PHNs and FTMOs) should inform people and patients about the referral chain and incentives for opting for referral system, etc.
- Outreach staff should inform people about preventive care
- Effective and efficient IEC material should be produced and made available to the health care providers for providing health information.
- Supervisory systems should include evaluation of use of IEC material.

**2. RIGHT TO INFORMATION ABOUT PREVENTIVE AND CURATIVE MEDICINE, AFTER-CARE AND GOOD HEALTH**

**IMPLICATIONS FOR BMC**

- System for upgrading technical knowledge of all staff at health posts and dispensaries (CHVs, ANMs, MPWs, Medical Officers). A system of Continuing Medical Education for all cadres should be developed.
- Establishment of information centres in health posts and dispensaries.
- IEC strategies need to be revised.
- Mechanisms for assessing the efficacy of strategies should be established.

**3. RIGHT TO HEALTH SERVICES FREE OF CORRUPTION AND POLITICAL INTERFERENCE**

***FREE OF POLITICAL INTERFERENCE***

- Politicians/corporators should not interfere with professional judgement and decisions.
- Procurement and distribution systems should be transparent.
- The health care delivery system should be accountable to the people.

**IMPLICATIONS FOR BMC**

- Review and, if required, revision of existing systems.
- Orienting corporators in the procedures followed at the health care centres and defining their role.
- Encouraging and developing strategies for community partnership in the management of health care facilities.

**4. RIGHT TO BASIC HEALTH CARE, EXPENSIVE LIFE SAVING TREATMENT AND EMERGENCY SERVICES AT HOSPITALS IRRESPECTIVE OF ABILITY TO PAY**

***BASIC HEALTH CARE***

- Preventive and promotive health care as provided through health posts and curative care as provided through dispensaries.

***EXPENSIVE LIFE-SAVING TREATMENT***

- Super-specialty treatment including treatment of heart conditions, neuro-surgical and neurological conditions, conditions/diseases of the kidney, cancers, treatment requiring intensive care services, etc.

***EMERGENCY SERVICES***

- The Working Group agreed that the definition should be evolved in consultation with a group of clinicians from municipal health care facilities.

**IMPLICATIONS FOR BMC**

- Removal of user fee of Rs 10 for dispensaries or investing medical officers with the authority to waive the fee for those unable to pay. Alternatively, the community could be involved and made responsible for arranging for the cost of treatment of those unable to pay. As an incentive, the BMC could make provisions for the funds generated through poor box fund for managing user fee in the health care centre.
- Decisions need to be made about which services should be considered life-saving and about the criteria to be used for exemption from user fee. A committee of experts could be formed for developing the criteria.
- Administrative procedures need to be reviewed to make the above possible.
- Identifying or developing a reliable, feasible procedure for assessing the paying capacity of of clients.



## 5. RIGHT TO EASY ACCESS TO ADEQUATE AND APPROPRIATE HEALTH SERVICES THAT ARE EFFECTIVE AND SENSITIVE TO COMMUNITY'S NEEDS

***EASY ACCESS***

- Easy access in terms of distance from residence, timings of the health services, financial affordability and cultural acceptability.

***APPROPRIATE HEALTH SERVICES***

- Services provided as per the norms set for that particular type of the facility (as described in referral protocols), with quality of services complying with the norms for quality of health care developed for the BMC.

***EFFECTIVE***

- Health services should meet the expressed health needs of the community for whom they are intended, and should be in compliance with prescribed norms of quality of care. For example, effective preventive services should lead to decline in the incidence of the particular condition.

***SENSITIVE TO COMMUNITY'S NEEDS***

- Besides performing its mandatory functions, the health care system should have mechanisms to assess the specific needs of the community it serves and must make efforts to meet these needs. For example, if there is a high incidence of diarrhoea among children in a particular area served by the health post, then specific measures such as health education to people, reporting the situation to the appropriate authorities, etc., are necessary.
- The system should also respond to the felt needs of the community as and when expressed. These may or may not be issues within the purview of the Public Health Department. For issues beyond the control of the Public Health Department, health care workers should work in liaison with other BMC departments as well as with other resource institutions. For example, if the community expresses the need to know about AIDS prevention, a session on the subject could be arranged; if there is a complaint about garbage in the community, health care providers should liaison with other ward-level departments through the appropriate authorities in the case of domestic violence, non-governmental organisations working on these issues could be approached.
- Particular attention should be paid to groups with special needs such as women, children and the elderly. This could be done by establishing special clinics for geriatric care, provision of post-menopausal services, etc. Both clinical and awareness generating services need to be initiated.

**IMPLICATIONS FOR BMC**

- Review existing health services in terms of accessibility and revise resource allocation if necessary.
- A guideline/standards for ensuring quality of care at each level of health care services should be developed. (This could also be developed as a part of referral protocols.)
- Supervisory mechanisms need to be oriented to assess the quality of care as per pre-defined norms.
- Administrative measures — punitive as well as rewards-based — need to be developed for ensuring quality of health care.

- Through health posts, BMC's needs assessment mechanisms should make conscious efforts to ensure that health care services are equipped to meet the needs of groups within the community with special requirements such as women, children, the elderly and other groups with special needs.

**6. RIGHT TO EXPECT PROMPT TREATMENT WITHIN AVAILABLE RESOURCES IN AN EMERGENCY IRRESPECTIVE OF CLIENT'S ABILITY TO PAY, DURING THE WORKING HOURS OF THE PRIMARY AND SECONDARY HEALTH CARE FACILITIES AND AT ALL TIMES IN CASUALTY DEPARTMENTS OF SECONDARY AND TERTIARY HOSPITALS.**

***PROMPT TREATMENT***

- Indicators need to be defined

***EMERGENCY***

- Needs to be defined

**IMPLICATIONS FOR BMC**

- Clinical as well as administrative protocols need to be developed for emergency care, ensuring prompt treatment.
- Implementation of these protocols to be ensured through monitoring mechanisms.
- Mechanisms for ensuring quality of care should be established.

**7. RIGHT TO ACCESS APPROPRIATE REDRESSAL PROCEDURES.**

***APPROPRIATE REDRESSAL PROCEDURES***

- Clients as well as providers should be made aware of situations in which the client is eligible to seek redress. Levels at which redress can be sought should be defined and clients and providers should be made aware of these.
- Various procedures such as maintaining a complaints book for clients or a complaint box that can be opened during the weekly meetings can be introduced. The complaints should be sent to the MOH for perusal and appropriate action. Increasing community participation in management of health care facilities by inviting community members to monthly or quarterly meetings will help establish a basis for the redressal system.

**IMPLICATIONS FOR BMC**

- Ensure quality of health care at all levels of health care facilities as per

the norms.

- Health care providers and administrators should be sensitised to the issues for which the clients can seek redress and implications of this for the health care facilities/providers.
- Guidelines should be developed for managing /addressing complaints registered by the clients.
- Implications of such complaints for the health care providers or facility concerned should be charted clearly. Provisions should be made for punitive actions in terms of reduction of points from annual appraisal of health care facilities. This could be entered into a Confidential History Sheet after careful verification and screening.
- Concrete steps should be planned for sensitising clients towards the issue of redress. Complaint boxes and information regarding the redress mechanism should be displayed in such a manner that it is clearly visible to clients as well as people from surrounding areas. Outreach staff should make the community aware of these steps.

**8. RIGHT TO HEALTH SYSTEM THAT ANTICIPATES MAJOR HEALTH HAZARDS, TAKES APPROPRIATE ACTIONS TO PREVENT THEM, AND IN UNFORTUNATE INSTANCES IS FULLY EQUIPPED TO ACT EFFECTIVELY TO CONTROL THE DAMAGE CAUSED BY HEALTH DISASTERS.**

***ANTICIPATES MAJOR HEALTH HAZARDS***

- The health care system should have mechanisms for continuous monitoring of various health indicators. It should be able to gather the relevant data, analyse it and predict outbreaks, etc., using epidemiological methods. Such systems should be in place at local as well as city level. Data should be gathered, analysed and used for planning activities at the level of the health care facility and should be also submitted to the appropriate authorities for studying the trends and performance of various health care facilities.

***... IS FULLY EQUIPPED TO ACT EFFECTIVELY***

- Based on the data gathered and educated forecasts, the system at all points in time should be in a state of alert and be able to act appropriately in case of health disasters. The health care system therefore should have a mechanism for evaluating its resources and skills regularly and be able to provide opportunities for upgrading relevant skills, knowledge and resources. A reliable and competent back-up system needs to be

developed and maintained in a state of alert.

**9. RIGHT TO BE REFERRED TO HOSPITAL/CONSULTANT WHEREVER APPLICABLE AS PER THE REFERRAL PROTOCOLS**

**IMPLICATIONS FOR BMC**

- Develop and implement referral protocol.
- Develop and implement norms for quality of care at each level of service delivery.
- Establish a monitoring system for ensuring implementation of referral protocols.
- Establish a system for redressal of complaints related to referral (this could be part of or the same redressal system as proposed for point no. 7).

**10. RIGHT TO BE TRANSFERRED TO ANOTHER HEALTH CARE ESTABLISHMENT ONLY AFTER AN EXPLANATION OF THE NEED FOR TRANSFER AND AFTER THE OTHER ESTABLISHMENT HAS ACCEPTED THE PATIENT**

**IMPLICATIONS FOR BMC**

- Develop and implement transfer protocols — clinical and administrative.
- Orient all health care providers to these protocols.
- Establish a monitoring system for ensuring implementation of protocols.

**11. RIGHT TO CLIENTS TO SEEK SECOND OPINION ABOUT THEIR DISEASE, TREATMENT, ETC.**

(**Note :** Whether the second opinion should be sought from a facility at the same level as the one where the patient is seeking treatment or whether the patient should be allowed to seek second opinion from municipal teaching hospitals and whether the patient should be allowed to choose the facility for second opinion was not agreed upon by the members of the Working Group. All members of the Working Group did not agree to right to second opinion.)

**IMPLICATIONS FOR BMC**

- Guidelines need to be developed regarding when a second opinion should be honoured by the doctor currently managing the patient.

**12. RIGHT TO POLITE BEHAVIOUR AND CONSIDERATE CARE.**

***POLITE BEHAVIOUR***

- Individuals seeking services should be treated as 'humans' and not merely

as 'cases'. Prejudices relating to class, gender, religion, etc., should not result in disrespectful or derogatory behaviour towards the clients. Health care providers' behaviour and verbal and non-verbal communication with clients should not hurt the latter's self-esteem or that of persons accompanying the client.

- Providers should try and answer questions raised by the clients or relatives in as simple a language as possible. If the health care provider is unable to help the client in any matter, the client should be referred to another professional who is in a position to help.
- Health care providers should maintain high professional standards at all times.

***CONSIDERATE CARE***

- Health care providers should refrain from judging the clients in any matter. It is appropriate to consider the social background of the client before forming any opinion about her/him.

**IMPLICATIONS FOR THE BMC**

- Health care providers need to be sensitised to aspects of communication/ interaction that are deemed by clients as insulting or hurting and efforts must be made to modify these. Relevant inputs or support as and when needed should be arranged to facilitate this.
- The redressal system should respond to complaints from the clients.
- Regular periodic satisfaction surveys should be conducted to ensure client satisfaction. Data from such surveys should be analysed at the facility level and used for planning interventions as necessary.
- Clients should be oriented to their rights and responsibilities.



## 13. RIGHT TO REFUSE TO PARTICIPATE IN HUMAN EXPERIMENTATION OR RESEARCH PROJECTS AFFECTING CLIENTS' CARE OR TREATMENT.

**IMPLICATIONS FOR BMC**

- All staff must be oriented to this issue.
- Clients should be oriented about their right to refuse participation in human trials.
- A rigorous system for monitoring human experimentation research projects, e.g., ethics committees, should be established.
- Guidelines for human experimentation should be developed and implemented.

### 14. RIGHT TO INFORMATION ON CAUSES, DIAGNOSIS, TREATMENT, MEDICINES AND PREVENTIVE MEASURES FOR A PARTICULAR CONDITION.

**IMPLICATIONS FOR BMC**

- Information material in various forms that are literacy-sensitive should be developed on conditions commonly seen at municipal health care facilities. Health care providers should be trained in using these materials and in basic counselling and communication techniques. The information material should be readily available at all health centres.

### 15. RIGHT TO BENEFIT FROM ADVANCES IN MEDICAL SCIENCES RELATING TO PATIENT'S CASE.

- The client should be given the choice of whether s/he would like to opt for newer treatments. The decision of opting for such treatment should be left to the clients after providing them with appropriate information regarding the advantages and disadvantages of the procedure, costs, risks, etc.

**IMPLICATIONS FOR THE BMC**

- Sensitisation of health care providers
- Orientation to clients that they have a right to choose and benefit from the advances in medical science relating to their case.

* * * * *

(Compiled from: Pondicherry Declaration on Health Rights and Responsibilities Manual of Patients by **ACASH**, People's Health Charter for Gujarat Final Draft of People's Health Charter)

ANNEX

T- 6.1

# Cleanliness Checklist for Municipal Health Care Facilities

## List of indicators for cleanliness inside the institution

| | Criteria | Marks |
|---|---|---|
| 1. | Toilet is clean | 10 |
| 2. | Regular and adequate water supply | 10 |
| 3. | Furniture is cleaned daily | 10 |
| 4. | Floor is swept daily | 10 |
| 5. | Floor is mopped daily | 10 |
| 6. | Walls and roof/ceiling is cleaned daily | 10 |
| 7. | Covered dustbin provided in each room | 10 |
| 8. | Dustbin is cleaned daily | 10 |
| 9. | Lights, fans and instruments cleaned weekly | 10 |
| 10. | Every week health centre washed with water | 10 |
| | **TOTAL** | **100** |

**Note**: 60% or more marks indicate satisfactory status of cleanliness.

## List of indicators for cleanliness in the compound

| | Criteria | Marks |
|---|---|---|
| 1. | Premises swept daily | 10 |
| 2. | Prompt removal of debris (within 2 days) | 10 |
| 3. | Prompt removal of solid waste (within 1 day) | 10 |
| 4. | Planting and maintaining a small garden around the institution wherever possible | 10 |
| 5. | Proper maintenance of compound wall (if present) | 10 |
| 6. | Wire fencing besides the compound wall | 10 |
| 7. | Inappropriate and waste material not found on the premises | 10 |
| 8. | No nuisance for community | 10 |
| 9. | Gutters and drains on the premises are not blocked | 10 |
| 10. | Open gutters, if any, should be clean | 10 |
| | **TOTAL** | **100** |

**Note**: 60% or more marks indicate satisfactory status of cleanliness.

T-6.2

## Patients' Charter for Health Care Services of the MCGM
*(Draft)*

### Patients' Rights

1. Right to information about the health services and making best use of them.
2. Right to information about preventive and curative medicine, after care and good health.
3. Right to health services free of corruption and political interference.
4. Right to basic health care, expensive life-saving treatment and emergency services at hospitals irrespective of ability to pay.
5. Right to easy access to adequate and appropriate health services that are effective and sensitive to the community's needs.
6. Right to expect prompt treatment within available resources in an emergency irrespective of client's ability to pay, during working hours of the primary and secondary health care facilities and at all times in casualty departments of secondary and tertiary hospitals.
7. Right to access appropriate redressal procedures.
8. Right to health system that anticipates major health hazards, takes appropriate actions to prevent them and, in unfortunate instances, is fully equipped to act effectively to control the damage caused by health disasters.
9. Right to be referred to hospital/consultant wherever applicable as per the referral protocols.
10. Right to be transferred to another health care establishment only after an explanation of the need for transfer and after the other establishment has accepted the patient.
11. Right to seek second opinion about disease/treatment, etc.
12. Right to polite behaviour and considerate care.
13. Right to refuse participation in human experimentation or research

projects affecting their care or treatment.

14. Right to information on causes, diagnosis, treatment, medicines and preventive measures for a particular condition.

15. Right to information about expected outcomes, side effects, after effects, chances of success, cost and availability of prescribed medication.

16. Right to obtain all the relevant information about the professionals involved in patient care, for example availability/timing.

17. Right to know what hospital rules and regulations apply to him /her as patient and the facilities obtainable to the patient (applicable to primary facilities — in terms of user fees, referral, etc.).

18. Right to get the details of the bill (receipts for amounts paid at MCGM health care facilities).

19. Right to benefit from advances in medical sciences relating to his/her case.

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(Compiled from: Pondicherry Declaration on Health Rights and Responsibilities; Manual of Patients by **ACASH;** People's Health Charter for Gujarat; Final Draft of People's Health Charter)

## Patients' Responsibilities

1. To provide accurate and complete information about their condition as required by the health provider.
2. To be punctual for appointments at clinic/hospital/dispensary for treatment.
3. To faithfully undergo the mutually agreed therapy.
4. To follow the doctors' instructions diligently.
5. To preserve all records for one's illness.
6. To accept all consequences for one's informed decisions.
7. To take the necessary preventive measures in case of infectious diseases as per the doctor's instructions.
8. Wherever applicable, to pay doctors/hospitals promptly for treatment received.
9. To respect and accept doctors' decisions..
10. To keep the present doctor informed if patient wants to change the doctor or line of treatment, or change to another system of healing.
11. To know and understand "Patients' rights" and to exercise them responsibly and reasonably.
12. To know and understand the purpose and cost of any proposed investigation/procedure/treatment before deciding to accept it.
13. To treat doctors and nurses with respect.
14. To be aware that doctors, nurses and paramedical staff are also human beings and need respite.

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(Compiled from: Pondicherry Declaration on Health Rights and Responsibilities; Manual of Patients by **ACASH** )

T-6.3

# Proposed Criteria for Ranking Primary Level Health Care Facilities

## *(Draft)*

| Activities | Source of information for monitoring | Maximum marks for each item | Minimum standard to be achieved |
|---|---|---|---|
| **A) Aesthetics: Total marks 30** | | | |
| *1.* ***Furniture*** | | (10) | |
| • Privacy for internal check up — Screens or curtains present **OR** | Observation | 4 | |
| • Existing furniture arranged to create privacy for the OPD | Observation | 2 | |
| • Arranged to create better patient flow<br>• Storage created within the existing furniture | Observation | 2 | |
| • Any other innovative arrangement | Observation | 2 | |
| *2.* ***Cleanliness ( i) Internal*** | Checklist | 10 | |
| ***(ii) External*** | Checklist | 5 | |
| *3.* ***Tidiness*** | Observation | 5 | |
| **B) Personnel: Total marks 35**<br>*1.* ***Punctuality*** | | | |
| • All the staff comes in time | Muster and surprise visits | 10 | |
| • Availability of the staff (whether on leave, gone out, etc.) and each person's responsibility is put up on the board | Observation | 5 | |
| • Programme outgoing book maintained at the facility | Observation | 5 | |
| 2) ***Staff wearing uniforms***<br>• Doctors wearing apron<br>• Dresser<br>• Labour<br>• Ayabai | Observation | (5)<br>2<br>1<br>1<br>1 | |
| 3) ***Staff members take part in special events***<br>• Street plays<br>• Community meetings/social functions<br>• Key trainer<br>• Part of committees<br>• Contributed to *Samvad* or any other newsletter or journal<br>• Presentation in CME<br>• Attendance in CME<br>• Attended special trainings and workshops<br>• Conducted men's activities<br>• Worked on Holidays<br>• (xi) Any other | | (10)<br>One point for each criterion | |
| **C) Drugs and Equipment: Total marks 60** | | | |
| 1) ***Drugs availability*** | | (30) | |
| • Mandatory drugs or emergency drugs | List of scheduled drugs to be prepared (using | 10 | |

| Activities | Source of information for monitoring | Maximum marks for each item | Minimum standard to be achieved |
|---|---|---|---|
| | the Standard Treatment Regimen KEM book) | | |
| • Supplementary drugs available | List to be used | 5 | 60% |
| • Efforts made to get the stock (requirement put up to the bureau) | Letter file | 5 | |
| • Used all the available drugs | Stock register | 10 | |
| 2) ***Equipment and gadgets*** | List of the minimum essential equipment to be prepared and used | (20) | |
| • Efforts made to maintain the equipment | Letter file | 5 | Reports sent to the ward office within one day and followed up promptly (—??——) |
| • Lab equipment for the upgraded laboratories | List of minimum essential equipment prepared | 5 | |
| • Number of laboratory tests done per month | Lab. Register | 10 | |
| **D) Patient's satisfaction, utilisation and community participation: Total marks 60** | | | |
| 1) ***How many patients (men, women and children) using different services (utilisation data)*** | Utilisation data | 10 | Number of old patients should be more than the new ones |
| 2) ***Are patients satisfied with the services given*** | Exit interviews (visual evaluation tool to be prepared) | 20 | |
| 3) ***Participation*** | | | |
| • Did community representatives attend the fortnightly staff meetings | Staff meeting minutes | 5 | Regular participation |
| • What action was taken regarding the issues raised by the community representative | | 5 | |
| • When was the suggestion box opened and what action was taken on the suggestions | | 5 | |
| • No complaints to the ward office from the community | | 5 | |
| • What activities were done with CBOs and NGOs | Reports of the activities | 5 | |
| • What community programmes did the staff attend | Report to be presented in the staff meeting | 5 | |
| **E) Information, Education, Communication (IEC): Total marks 35** | | | |
| 1) ***IEC corner at the facility maintained well*** | | | |
| • Whether material was displayed according to themes | Observation | 10 | |
| • Whether material was displayed in the appropriate place (visible to most of the users) | Observation | 5 | |
| • Whether people read and make use of the information put up on the walls of the health post | Spot evaluation methods of assessing need to be developed | 10 | |
| 2) ***Information on available services and timetable displayed at the facility*** | Observation | 5 | |

TOOL

Fact Sheet 7

# RESEARCH

## Rationale

From the research perspective, WCHP enjoyed a unique position as part of the collaboration between the Public Health Department, an academic institution and a non-government organisation. Its placement within the hierarchy of Public Health Department allowed the project an opportunity to study the system from within. Over the project's duration, WCHP was able to carry out many small research studies. Most of these were exploratory and served the purpose of capacity building as well as of documenting situations before and after interventions. Health care providers from the project wards were involved in planning, data collection and analysis of the research studies. The aim of involving health care providers in the research was to ensure that the results of the studies would be owned by the providers, thereby motivating them to implement changes, get an insight into the research process and develop skills for a more needs-based approach. Findings of the research studies were used by the project to develop interventions and to assess their impact.

**Salient features of research in WCHP**

- Participatory — health care providers involved in the research as partners
- Empowering — findings from the research studies were shared with health care providers
- Educational tool — exploratory research helped enhance the WCHP's understanding of various aspects of the health care deiivery system

## Activities

Research studies conducted by the project (Annex 7.1) can be divided into following broad categories:

- **Background studies:** When the project began, information was gathered on the health care needs of the community's men and women as well as on the perceptions of providers vis a vis quality of care. The findings of these studies formed the basis of various interventions proposed by the project and gave direction to the project's activities.

- **Baseline studies:** Initially, three studies were conducted to document health care delivery. These were (*a*) exit interviews to assess client satisfaction with municipal health care services, (*b*) providers' perspective on women's health and quality of care, and (*c*) facility study. The findings of these studies helped identify issues for intervention and served the purpose of baseline studies for the broader issues. The first of the studies mentioned under each specific intervention may be regarded as the baseline for that particular component.

- **Pilot interventions for Quality Assurance:** These were the outcome of the QA workshops (discussed in fact sheet 4) conducted for a cross-section of health care providers from the project area. Active participation by health care providers in the planning, development of tools, data collection and analysis of these studies makes them a milestone in the project's progress.

- **Fallout of the pilot interventions for QA:** A number of smaller research exercises were carried out to further explore certain issues emerging from the pilot interventions.

- **Men's involvement:** Exploratory studies were conducted to understand various issues related to men's responsibilities in reproductive health.

- **Counselling and information centre:** The establishment of the centre has its roots in the communication study that was one of the three pilot interventions for Quality Assurance. Various smaller studies were later conducted to document the impact of the centre on client–provider communication.

- **Gynaecology clinics at health posts:** As a part of its objective to expand the range of reproductive services, the project initiated gynaecology clinics at eight primary level health centres (health posts and dispensaries). WCHP conducted a feasibility survey prior to the initiation of these clinics. Client satisfaction surveys were also conducted during the midterm and end-evaluation of the project.

- **Development of IEC:** Development of client-centred, interactive IEC material was one of the major interventions of the project. This material was developed based on clients' needs for information. Studies were also conducted to assess the impact of the IEC material as well as that of the training on using such material.

## Achievements

- Involvement of health care providers in the baseline studies resulted in the providers 'owning' the studies.
- The active involvement of the IEC Cell members in field evaluation of material developed by the cell helped increase acceptance of feedback among the MCGM providers.
- The smaller studies served to identify information gaps and emphasised the need for an organised structure (research cell) within the Public Health Department.

## Constraints

Constraints mentioned below pertain to the participatory research that the project aimed at:

- Lack of space for health care providers to carry out exploratory research and design interventions in the Public Health System.
- It was difficult to convince administrators of the need to involve grassroots health providers in research, as research is not considered an essential part of designing interventions and IEC materials in MCGM. Health care providers are not encouraged to review and analyse routine service data at the facility level.
- MCGM lacks structures for supporting providers to develop and regularly upgrade their research skills.

## Lessons Learnt

- Active involvement of primary level health care providers in every stage of research helps build ownership of the intervention.
- Support structures within the public health system are essential for upgrading the research skills of the providers.
- Small research studies at regular intervals will help in routine monitoring of activities.

## Recommendations

- A research cell should be established within the Public Health Department and appropriate staff from all levels should be involved in the research activities.
- Conscious efforts must be made to integrate research as a part of the monitoring system and to involve primary level workers in the research process.

***Expectations From Deputy Executive Health Officers (DEHOs)/ Assistant Health Officers (AHOs)***

- Encouraging and supporting small research studies to improve quality of services and analysis of data at facility level.
- Acknowledging individuals who show such initiative.

## Contribution of Resources for Research

| Resources contributed by MCGM | Resources contributed by the Project |
|---|---|
| • Permission to conduct research in various health care facilities<br>• Statistical Officer assigned to the project for the initial three out of the seven years of the project | • Planning of research studies<br>• Data management and analysis<br>• Report writing<br>• Stationery and other material required during the training<br>• Salaries of research coordinator, research officer, research assistant and investigators |

## List of Annexes

Annex 7.1: Details of various research studies carried out by the project

# Annex 7.1

## Details of various research studies carried out by the project

| Sr. No. | Month/Year | Study | Objectives |
|---|---|---|---|
| **1.** | **BACKGROUND STUDIES** | | |
| 1. | April 96–March 97 | Waiting time at teaching hospital and maternity homes | • To document waiting time at different levels of health care facilities |
| 2. | 1996 | Social analysis of selected health posts | • To identify representative health posts from two project wards for conducting focus group discussions |
| 3. | 1996 | • Interviews with men from the community<br>• Interviews with women from the community<br>• Interviews with adolescent boys from the community<br>• Interviews with adolescent girls from the community | • To explore health care needs and health-seeking behaviour<br>• To explore perceptions about health posts |
| 4. | 1996 | Interviews with staff from health posts (H/E) | • To explore providers' perception of quality of care |
| **2.** | **BASELINE STUDIES** | | |
| 5. | April–December 1997 | Review of health care facilities | • To document quantitative information about infrastructure available to health posts, dispensaries and maternity homes |
| 6. | November–December 1997 | Health care providers' perceptions on health care services<br>70 health providers — medical, paramedical and community health volunteers —— from four dispensaries, four health posts, two PPCs, one maternity home and one general hospital from project area | • To understand the providers' perception of and attitude towards women's health and related issues |
| 7. | April–December 1997 | Client satisfaction study through exit interviews:<br>402 users of the OPD health services provided by the dispensaries, health posts, PPCs, Urban Health Centre and General Hospital were interviewed within the premises of these facilities and another 40 users of the health post outreach services were interviewed in their homes by trained investigators. | • To find out users' awareness about the health services provided by various health facilities of the MCGM<br>• To document costs incurred by clients on availing the services<br>• To explore whether clients were satisfied with the services and to elicit suggestions for their improvement |

| Sr. No. | Month/Year | Study | Objectives |
|---|---|---|---|
| **3. PILOT INTERVENTIONS FOR QUALITY ASSURANCE** | | | |
| 8. | February 1998–May 1999 | Action Research for improving the referral system | • To improve referral systems by ensuring optimum utilisation of the three-tier health care system, and<br>• Establish a feedback system to build links between different levels of the system |
| 9. | March 1998 | Monitoring client–provider communication | • To explore the feasibility of monitoring and improving communication of all cadres of providers using an observation checklist<br>• To explore the possibility of developing mechanisms for regular monitoring of client– provider communication within the public health care system |
| 10. | April–August 1998 | Drugs monitoring study: An action research study designed to serve the dual purpose of monitoring drug supply to clients and as an intervention for improvement in supply of drugs | • To develop a tool to monitor availability of drugs for clients at dispensaries.<br>• To examine whether the tool developed was effective in monitoring the distribution of drugs to the patients |
| **4. FALLOUT OF THE PILOT INTERVENTIONS FOR QA** | | | |
| 11. | January–May 1999 | Drugs availability study at gynaecology OPD of secondary hospital | • To document the extent of inadequacy of drug supplies |
| 12. | 1999 | Exploratory study of indenting and procurement procedure of MCGM | • To study the indenting and procurement system for drugs in MCGM in order to gain a better understanding of the non-availability of drugs to clients |
| 13. | 1999, 2001 | Monitoring client–provider communication at the gynaecology OPD of a secondary hospital | • To identify factors affecting client–provider communication<br>• To explore unmet information needs of clients |
| 14. | | Pharmacist study | • To document time allocation for routine activities of the pharmacists<br>• To explore the feasibility of using a modified checklist for monitoring drugs availability to clients |
| **5. MEN'S INVOLVEMENT** | | | |
| 15. | 1998 | In-depth interviews with ANMs — 5 | • To understand the work pattern<br>• To explore ANMs' views about men's involvement in women's health<br>• To find out problems with men's involvement<br>• To obtain suggestions regarding strategies for involving men<br>• To understand women's attitude towards family planning |
| 16. | 1998 | In-depth interviews with CHVs — 5 | • To understand the work pattern of CHVs and to find out if they communicated with men in the community |
| 17. | March to September 1998 | In-depth interviews with MPWs — 8 | • To find out opportunities where the workers meet men during the course of their work |
| 18. | June 1998, October 1999 March 2000 | Protocol for study on men's involvement in women's health | • To understand the nature and extent of husbands' involvement in health seeking and women's expectations from their husbands in terms of support during illness |

| Sr. No. | Month/Year | Study | Objectives |
|---|---|---|---|
| 19. | November–December 2000 | Study on understanding barriers in men's involvement in Women's health: 40 men and 3 health care providers were interviewed | • To find out difficulties/obstacles faced by men accompanying women to the outpatient clinic of the hospital<br>• To explore health care providers' views about involving men in women's health |
| **6. COUNSELLING AND INFORMATION CENTRE** | | | |
| 20. | 2001 | Exercise for validation of exit interviews as tool for gathering information on client provider communication with observation technique | • To explore possibility of use of exit interviews in place of observations for documenting client-provider communication. |
| 21. | 2001 | Baseline for counselling centre at VND hospital | • To document client–provider communication at the gynaecology OPD<br>• To identify need for counselling |
| 22. | 2002–2003 | Assessing impact of the counselling centre at the gynaecology OPD | • To document impact of the counselling and information centre on providers' style of communication and information given to clients |
| **7. GYNAECOLOGY CLINICS AT HEALTH POSTS** | | | |
| 23. | 1999, 2003 | Review of staff and instruments at health posts and dispensaries | • To document staff and instruments available at health posts and dispensaries<br>• To assess feasibility of initiating/continuing gynaecology clinics at health posts and dispensaries |
| 24. | 2000 and July 2003 | Exit interviews at gynaecology clinics at health posts | • To explore areas that need to be strengthened for sustainability of the clinics<br>• To identify strategies for mainstreaming the clinics<br>• To explore the implications for the implementation of Urban RCH programme |
| **8. DEVELOPMENT OF IEC MATERIAL** | | | |
| 25. | 1998–1999 | Study of media preferences by men and women from the community | • To document media preferences of men and women with reference to health information |
| 26. | December 1998 | Review of IEC material | • To review existing IEC material<br>• To collect information about usefulness of IEC material<br>• To study the process used by the IEC Cell to distribute material to the concerned health set-ups<br>• To study the pattern of storage and dissemination of the material in hospitals and field areas<br>• To identify the IEC material used by each type of health care facility |
| 27. | March–August 1999 | Focus group discussions with men (4) and women (6) | • To explore awareness about MCGM's health services — especially health posts and health care providers<br>• To understand information needs<br>• To enable IEC Core Committee members to realise the importance of incorporating peoples' perception into the preparation of IEC material |
| **9. EVALUATIVE STUDIES** | | | |
| 28. | 1998 | Pilot study<br>PID ANMs – 5<br>WCHP ANMs – 3<br>Control ANMs – 5 | • To find out from the PID ANMs the changes that have taken place in their perceptions regarding women's health<br>• To find out what new knowledge they have gained |



WH-105

| Sr. No. | Month/Year | Study | Objectives |
|---|---|---|---|
| | | | through the training given to them<br>• To find out what new skills they developed as a result of the training<br>• To find out any personal changes experienced by them.<br>• To find out from other health post staff who are presently working with these PID ANMs, their perceptions of PID ANMs |
| 29. | July 1999 | Midterm evaluation of the project | • To assess the effectiveness of training inputs provided by the project<br>• To explore health care providers' opinions about various test interventions introduced by the project in order to assess the feasibility of mainstreaming the interventions<br>• To document changes in perspective and attitudes of key trainers and members of committees established by the project |
| 30. | 2000 | Evaluation of ANMs trained during the PID Project, WCHP and ANMs from control areas (PID = 15, WCHP = 12, Control = 15) | • To find out from ANMs the changes that have taken place in their perceptions regarding women's health<br>• To find out what new knowledge they have gained through the training given to them<br>• To find out what skills they have developed as a result of the trainings<br>• To find out from the ANMs, the personal changes experienced by them |
| 31. | April–August 2003 | End-evaluation of the project | • To assess the impact of interventions by the project<br>• To explore feasibility of mainstreaming these interventions in the Public Health Department of MCGM |

# PART II

# INTERVENTIONS

## Introduction

As mentioned earlier, the Women Centred Health Project was developed as a model to demonstrate the feasibility of expanding the range and improving the quality of reproductive health services provided by MCGM's primary level health care facilities. Based on the findings of the exploratory studies carried out by the project and issues that emerged from various workshops, test interventions were developed and pilot tested. These included establishing gynaecology clinics at primary health care facilities, setting up a counselling centre at the gynaecology outpatient department of a municipal secondary general hospital, developing client-centred, interactive IEC material, monitoring client–provider communication, monitoring drugs supply and developing draft protocols for gynaecological referrals.

The Public Health Department accepted some interventions more readily than others. However, all the test interventions developed by the project are valuable examples of measures for improving quality of care. All fall well within the resources available with the public health system, with only minimal inputs from external agencies.

This section describes the rationale behind each test intervention, the activities involved in developing and piloting the interventions, achievements, constraints and proposed responsibilities of administrators and supervisors at different levels of the public health system's hierarchy.

Key activities that formed the bases for almost all the interventions, achievements relating to the tested interventions and the constraints experienced by the Project are presented below. Those relating to specific test interventions are discussed in Fact Sheets.

## Activities

- Capacity building of the WCHP team and selected health care providers from the system to enable a better understanding of issues related to the quality of reproductive health services.

- Research to identify issues and explore the importance of identified issues in the provision of quality reproductive health care.
- Participatory development and piloting of test interventions to encourage ownership.
- Assessment of effectiveness of test interventions.

## Achievements

- The project was successful in involving primary level health care providers and middle level administrators in all phases of developing and piloting test interventions. This resulted in increased ownership of these interventions among the providers.
- Establishment of gynaecology clinics at primary health care facilities and their successful utilisation demonstrated the possibility of providing a wider range of quality gynaecological services at the community level. These clinics also helped to boost the morale of grassroots health care providers.
- Modification in the layout of the outpatient department to facilitate patient flow helped improve client–provider communication. The positive response to the counselling centre at gynaecology outpatient clinic of a municipal secondary hospital demonstrated the felt need for reproductive health counselling services at municipal hospitals. Both these could be modes of implementation of RCH II through MCGM.

## Constraints

- Insufficient resources to upscale interventions.
- Slow response of the system to the need for up-scaling interventions.

Fact Sheet 8

# ESTABLISHING GYNAECOLOGY CLINICS AT THE PRIMARY LEVEL

## Rationale

A major need expressed by the women interviewed during the PID study, of which the WCHP is an offshoot, was for primary services that can diagnose and treat a wide range of gynaecological conditions closer to their homes. Another important issue brought to light by this study was the need expressed by women for their male partners to share responsibility for reproductive health.

Expanding the range of services provided by health posts and dispensaries, particularly those relating to reproductive health conditions, was one of the most important interventions of WCHP. The project explored various ways in which good quality services could be dispensed under the national programme on Reproductive and Child Health (RCH).

## Activities

- The first step was to train clinicians, ANMs, MPWs, CHVs and laboratory technicians. However, given the constraints of time and resources, the project focused on four reproductive tract conditions that are commonly seen in general practice: (*a*) menstrual disorders, (*b*) childlessness, (*c*) reproductive tract infections, and (*d*) antenatal care.
- Continuing Medical Education (CME) sessions were initiated for clinicians from the project wards. A clinical subcommittee comprising expert clinicians, senior faculty from the teaching hospitals and clinicians from dispensaries, health posts and maternity homes was formed to provide guidance.
- Clinicians were encouraged to set up reproductive health clinics at health post and dispensary. Towards this end, essential prerequisites for starting gynaecology clinics were identified.
- Efforts were made to meet the prerequisites by mobilising available resources within the MCGM health care system, e.g., instruments. Where the system could not help, the project assisted by procuring the necessary materials, e.g., curtains for ensuring privacy.

| Prerequisites for Conducting Gynaecology Clinic at Health Post/Dispensary | | |
|---|---|---|
| **PHYSICAL STRUCTURE**<br>• Adequate privacy for PV examination (curtains or a separate room, covering sheets)<br>• Adequate water supply<br>• Toilet facility | **STAFF POSITION**<br>• Medical officer<br>• Lady assistant (PHN/ANM/CHV)<br>• More than 50% of staff in place | **EQUIPMENT**<br>• Sterilising equipment/Pressure cooker<br>• Gynaecological instruments<br>• Cusco's Speculum |
| **MEDICINES** ( Nos. 1–16: List specified by NACO) | | |
| 1 Ciproploxacin<br>2 Azethromycin<br>3 Erythromycin stearate<br>4 Miconazole<br>5 Metronidazole<br>6 Fluconazole | 7 Clotrimazole<br>8 Aq. Procain Penicillin<br>9 Benzathine Penicillin<br>10 Ceftriaxone<br>11 Spectinomycine<br>12 Cefixime | 13 Acyclovir<br>14 Vaginal Pessaries<br>15 Tetracycline<br>16 Antiseptic like Savlon<br>17 Doxycycline |

- The project liaised with Mumbai District AIDS Control Society (MDACS) to ensure regular and adequate supply of drugs. It was agreed that MDACS would supply the four most commonly required drugs, namely Candid V1 Pessary, Fluconazole, Doxycycline and Metronidazole for treatment of reproductive tract infections. On its part, the project would submit to the MDACS a monthly report on the consumption of these medicines (for format see T-8.1). Regular and adequate supply of medicines has enhanced staff motivation and helped ensure regular gynaecology clinics — demonstrating to the community the benefits of collaboration between two government agencies — MDACS and MCGM.
- Gynaecology clinics were started in seven health posts and one dispensary over 2001–2003 with the active involvement of the Medical Officers of Health (MOH) and the Community Development Officers (CDOs). Medical officers at all gynaecology clinics maintained records on all clients in a pre-determined format. (T-8.1).
- A checklist was developed and is used regularly to assess the quality of clinical services (T-8.3). The project arranged for consultant gynaecologists from post partum centres and MCGM's peripheral hospitals to pay at least one supervisory visit to the gynaecology clinics every month. During these visits the supervising gynaecologists review case records of clients seeking gynaecological services to assess and document the quality of clinical services and discuss cases or answer questions. The checklist also allows for documentation of the administrative aspects of the clinics.
- Training programmes were organised to orient the ANMs, PHNs and MPWs at the gynaecology clinics to the concepts of gender, counselling

and men's involvement in reproductive health. Selected representatives of the staff at attached to gynaecology clinics at health posts participated in 'Sexuality Communication' workshops that aim at sensitising participants to the importance of non-judgmental and non-discriminatory attitudes towards clients, good communication and barriers to behaviour change for HIV/AIDS prevention.

- MPWs and ANMs were trained to provide counselling on gynaecological conditions, to men in the case of MPWs and women in the case of ANMs.
- The project initiated and facilitated the active involvement of medical officers in charge of wards in procuring drugs from MDACS.

## Achievements

- Gynaecology clinics were started at seven health posts and one dispensary, thus building a demonstration model for MCGM.
- The medical officers now treat the four reproductive health conditions mentioned earlier. In most cases, the treatment is symptomatic, in some cases based on internal investigations. Records on each case are maintained in a register. This allows for easy assessment of the quality of clinical care. Further details are presented in T-8.3.
- Training provided by WCHP includes the social and clinical aspects of each selected condition. During the midterm evaluation, ANMs reported applying the knowledge/skills of communication in the field, for situations relating to not only childlessness and menstrual problems but also TB and family planning.
- The training for CHVs emphasised their role in the treatment of reproductive tract conditions. Following the training, the CHVs were asked to identify and refer women with menstrual disorders and reproductive tract infections to the health post.
- Health post staff reported that after training, there was an increase in the number of women referred by CHVs to the health post for treatment.
- Lessons learned from the project in starting the gynaecology clinics were incorporated in the training modules for urban RCH and were shared with all health care providers of the Public Health Department.

## Constraints

- Lack of staff due to unfilled vacancies is the biggest obstacle to starting gynaecology clinics at all health posts and dispensaries.

- Two training workshops were conducted for laboratory technicians. However, practical work in the dispensaries could not begin immediately after the training in November 1998 since the reagents and glassware required for investigations were not available. In December 1999, another round of refresher training was organised and, following the training, reagents were provided by the project. So far the dispensaries have not reported conducting any investigations related to the selected four reproductive health conditions because, as the technicians said in their feedback, they do not have time for any further work. In response, the project carried out an observation study to document the technicians' workload and time spent per investigation. The study revealed that laboratory assistants are required to assist the technicians. Vacancies in laboratory technicians' posts and a ceiling on recruitment were further obstacles in conducting investigations for reproductive tract infections.
- For a long time non-availability of physical resources (including arrangements for privacy) and delays in getting equipment repaired due to administrative procedures delayed provision of reproductive health services and conducting investigations.
- Delays in following up clinicians' training with adequate logistics support resulted in dampening the enthusiasm of doctors and further delaying implementation of RH services.
- Non-availability of female assistants for conducting Per Vagina (PV) examination where male medical officers are posted in dispensaries also resulted in PVs not being done..
- In the H/E ward vacant FTMOs' posts — only one FTMO is posted for six health posts — and less than 50 per cent staff in all health posts prevent regular gynaecology clinics from being conducted.
- Vacant staff positions (FTMOs, ANMs and MPWs) in health posts in G/N and H/E wards has increased the workload of current staff.
- Lack of coordination between the MO i/c of the dispensary and the full-time MO at the health posts results in the discontinuation of reproductive health services when the FTMO or MO i/c of the gynaecology clinic is absent. This can reduce credibility of the health care delivery system.
- The present MIS system does not include the number of patients (and their partners) treated for RTI and STI. Since there is no demand for these statistics from the top, there is a lack of motivation for keeping required records.

- The reporting format provided by MDACS was unsuitable for documenting cases seen at the gynaecological clinics at health posts. This proved to be an obstacle in mainstreaming MIS for these clinics. To overcome this, the project proposed an alternative monthly reporting format, which is presented in T-8.2.

## Lessons Learnt

- Collaboration with an HIV/AIDS agency can be valuable to the health care delivery in terms of implementingreproductive health services.
- Simultaneous provision of technical and administrative inputs is crucial for the success of gynaecology clinics at health posts and dispensaries.
- Availability of adequate staff is essential for the regular functioning of gynaecology clinics. Absence of the medical officer conducting the gynaecology clinics for a long period can de-motivate clients from approaching gynaecology clinics.
- Demand generation by increasing awareness of the reproductive health services provided at the primary level is essential for making the services viable.

## Recommendations

- The functions of the health post and dispensary, whenever located on the same premises, should be integrated. This will ensure that the gynaecology clinics continue to function even in the absence of the medical officer who routinely conducts the clinic. Indicators for ensuring functional integration are presented in T-8.5. A weekly activity plan for the proposed integrated health centre is presented in T-8.4.
- Of the two medical officers posted at the integrated facility, at least one should be female.
- Policylevel decisions are necessary for filling up vacancies and making available the physical resources necessary for providing reproductive health services. Strengthening peripheral services, including maternity homes in terms of staff, is important for providing quality referral gynaecological services.
- Refresher training for management of gynaecological conditions should be given to all health care providers at regular intervals.
- A system of routine monitoring by consultant gynaecologists using a monitoring checklist and CMEs should be initiated to ensure quality of clinical care.

- A system for regular and consistent supply of drugs should be developed/ identified.
- Administrative procedures for indenting medicines, supplies and repairs should be streamlined.
- The amount for minor expenses allocated to health posts and dispensaries should be increased to enable speedy repair of equipment.
- Standby equipment like the BP apparatus and stethoscope should be kept at the ward office.
- Audits of clinical procedures should be implemented (at present it is carried out by hospital consultants on a voluntary basis).
- Training to Community Health Volunteers, who comprise the first level of contact for community, will help generate demand for services. Such training workshops should be conducted regularly.

***Expected Role of Deputy Executive Health Officers (DEHO) / Assistant Health Officers (AHO)***

- Functional integration of health post and dispensary whenever both located in the same premises and monitoring of the same during supervisory visits.
- Of the two medical officers posted at the integrated facility, at least one should be female.
- Policy-level decisions for filling up vacancies and providing the necessary physical resources.
- Increase in the amount allocated to health posts and dispensaries for minor expenses to enable speedy repair of equipment.
- Streamlining administrative procedures for indenting and repairs.
- Administrative consent for keeping standby equipment (33 per cent) in ward office.
- Zonal DEHO to ensure that technical supervision is done with the help of a checklist.

***Expected Role of Medical Officers of Health (MOHs)***

- Smaller repairs to be carried out through local contractors using the imprest amount.
- Streamlining administrative procedures for indenting and repairs.
- Standby equipment should be made available at the ward office.
- Using a checklist for monitoring activities for supportive supervision.

## Resources required for starting Gynaecology Clinics at Health Posts and Dispensaries

| Contributions of MCGM | Contributions by the Project |
|---|---|
| • Space for clinic and staff<br>• Instruments and equipment (e.g., speculum)<br>• Sterilisation equipment or autoclaves<br>• PV examination tables<br>• Supervision by gynaecologists | • Personnel to coordinate changes necessary to start gynaecology clinics<br>• Curtains for ensuring privacy<br>• Personnel for regular monitoring and liaison with MDACS<br>• Repair of equipment and furniture<br>• Stethoscopes, BP instruments to all clinics and steriliser and lamp to one clinic each<br>• Honoraria to clinical supervisors<br>• Training to clinicians and other staff (including CHVs) |

### List of Tools

T-8.1 : Format for Client Records

T-8.2 : Proposed Format for Monthly Reports

T-8.3 : Checklist for Assessment of Quality of Care

T-8.4 : Weekly Activity Plan for the Proposed Integrated Health Centre

T-8.5 : Indicators for Ensuring Functional Integration

T-8.1

# FORMAT FOR CLIENT RECORDS

| Sr. no. | Date | Out - patient clinic no. | Name and address of the client | Clinical history | Examination findings | Diagnosis | Treatment to client | Treatment to partner | Follow-up/special investigations |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | |
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T-8.2

# PROPOSED FORMAT FOR MONTHLY REPORTS

**Name of Facility : .....** **Ward : .....** **Month.....**

| Type | Old patients | New patients | Number of cases counselled as per checklist | | Total | |
|---|---|---|---|---|---|---|
| | | | Women | Men | Women | Men |
| Menstrual problems | | | | | | |
| Childlessness | | | | | | |
| ANC | | | | | | |

| | Women | Men | Partner treatment | | Women | Men | Partner treatment | | | | Women | Men | Partner treatment | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | Medicines | Condom | | | Medicines | Condom | | | | | Medicines | Condom |
| Reproductive tract infections | | | | | | | | | | | | | | |
| Sexually transmitted infections | | | | | | | | | | | | | | |

* Please refer to the 'Counseling Checklist' (T-10.1).

T-8.3

# CHECKLIST FOR ASSESSMENT OF QUALITY OF CARE

## A. Technical Supervisory Checklist

**Name of Facility :** .....  **Date :** .....

| Sr. No. | | No. of cases reviewed | Satisfactory | Non-satisfactory | Inadequate | Remarks |
|---|---|---|---|---|---|---|
| 1 | History taking | | | | | |
| 2 | Examination | | | | | • Reasons for not doing PV |
| 3 | Investigation | | | | | |
| 4 | Management | | | | | • Drugs — reasons for non-availability<br>• Partner treatment |
| 5 | Referral | | | | | • Reason for referral<br>• Facility referred to |
| 6 | Follow-up | | | | | |

**B. Administrative checklist**

| | | | |
|---|---|---|---|
| | **Available Quantity** | | **Remarks** |
| Drug supply | | | Reasons for non-availability |
| Gloves | | | |
| **Instruments and equipment** | **Working condition** | | **Remarks** |
| | **Working** | **Non-working** | Reasons |
| Sterilisation procedure followed | | | |
| | **Adequate** | **Inadequate** | **Remarks** |
| Water supply | | | Reasons for inadequacy |
| Privacy | | | |
| Staff availability | Normal | Staff present on day of visit | |
| **Training needs identified** | | **Action Plan to be summarised from remarks** | |
| | | | |

**Copy to MOH**

**Note:** The technical checklist allows supervisors to review the clinical management of, as well of counselling and information provided to clients and their husbands. It is expected that better quality of care will result in accurate clinical management and referral as reflected from the records, increased proportion of partner treatment for women reporting RTIs and increased proportion of women counselled and referred for conditions that can not be treated at the health post level. The technical checklist is to be used by gynaecologist–supervisors. The administrative checklist reviews essential prerequisites for provision of reproductive health care. Availability of these resources indicates a conducive environment for provision of quality reproductive care. The administrative checklist can be used by CDOs, MOsH, AHOs (Zone) or any other administrative officers. It can also be used by the staff of the health post with gynaecology clinics as a tool for 'self evaluation'. One limitation of the tool is that it relies on records and therefore the honesty of the recorder.

T-8.4

# Weekly Plan of Activities for the Proposed Integrated Health Centre

| Day | Facility (Centre) | | | Outreach | |
|---|---|---|---|---|---|
| | Time | Activity | Person responsible | Activity | Person responsible |
| Monday | AM | General outpatient clinic | MO i/c., FTMO in absence of MO i/c | Cleansing and Fine collection (full day)<br>Home visits ( 3 hours)<br>Routine (20 Households) | FTMO |
| | PM | General outpatient clinic<br>Family Welfare and Counseling | PHN to coordinate ANM, FTMO.<br>MO for Cu-T | Goal based (20 Households)<br>Goal based (20 households) | CHVs<br>ANMs<br>MPWs |
| Tuesday | AM | General outpatient clinic<br>Immuniation | MO i/c FTMO, PHN, ANM, CHV | Home visits (3 hours)<br>Routine (20 Households) | CHVs<br>ANMs |
| | PM | General outpatient clinic, Well Baby Clinic, Family Welfare and Counseling | MO i/c, FTMO, PHN to coordinate ANM | Goal based (20 Households)<br>Goal based (20 Households) | MPWs |
| Wednesday | AM | General outpatient clinic | MO i/c, FTMO | Home visits (3 hours)<br>Routine (20 Households) | CHVs<br>ANMs |
| | PM | General outpatient clinic, Well Baby Clinic, Family Welfare and Counselling | MO i/c, FTMO, PHN to coordinate ANM | Goal based (20 Households)<br>Goal based (20 Households) | MPWs |
| Thursday | AM | General outpatient clinic | MO i/c, FTMO | Immunisation camp ( 3 hours)<br>Home visits (3 hours)<br>Routine (20 Households) | FTMO<br>PHN<br>CHVs<br>ANMs |
| | PM | General outpatient clinic, Family Welfare and Counselling<br>Antenatal care | MO i/c, FTMO, PHN to coordinate ANM | Goal based (20 Households)<br>Goal based (20 Households) | MPWs |
| Friday | AM | General outpatient clinic | MO i/c, FTMO | Cleansing (Adopted slums) (3 hours)<br>Home visits (3 hours)<br>Routine (20 Households) | FTMO, PHN, ANM, HPA, CHVs, ANMs, MPWs |
| | PM | General outpatient clinic, Family Welfare and Counselling, Antenatal care, Well Baby Clinic | MO i/c, FTMO, PHN to coordinate ANM | Goal based (20 Households)<br>Goal based (20 Households) | |
| Saturday | AM | General outpatient clinic | MO i/c, FTMO | Immunisation camp (3 hours)<br>Home visits (3 hours)<br>Routine (20 Households) | FTMO, PHN, ANM, HPA, CHVs, ANMs, MPWs |
| | PM | Review meetings, Continuing Medical Education sessions, Records/Reports | MO i/c, FTMO | Goal based (20 Households)<br>Goal based (20 Households) | |

**Note:** Whenever the full-timeMedical Officer (FTMO) iis not in the field for the outreach programmes in the morning, she/he would share the general outpatient clinic responsibilities with the Medical Officers in charge (MO i/c) of dispensaries. In the afternoon, for special clinics, the MO i/c should help the FTMO. The Public Health Nurse (PHN) should coordinate the afternoon special clinics. The ANMs should assist her in organising the special clinics.

T-8.5

## Indicators for Ensuring Functional Integration of Health Post and Dispensary

*(Note: The information is related to the reporting month only)*

Name of the facility Independent/Combined

Report for the month

1. Average daily utilisation: _____

2. Whether waiting space for patients available? Yes/ No
   - If yes, whether it is adequate? Yes/No
   - If no, where did the patients wait?
   - Is the space of the other facility used for any other purpose? Yes/No
   - If yes, for which purpose?

3. Whether there is a room with an examination table? Yes/No
   - If yes, was it shared by the two facilities? Yes/No
   - If yes, how many times?
   - For what purpose?

4. Whether the instruments of the other facility were shared? Yes/ No
   If yes, - which instruments?
   - on how many days?

5. Number of days the following work was shared

| Work | Medical Officer (in charge) | Full-time Medical Officer |
|---|---|---|
| A General outpatient clinic | _____ days | _____ days |
| B Special outpatient clinic | _____ days | _____ days |

6. Whether any help was taken from the staff of the other facility? Yes/No
   If yes, - from whom?
   - how many times?

7. Whether any meetings took place with the other facility? Yes/No
   If yes, with whom?
   Topic/s of the meetings

8. Any other joint activities

9. Problems encountered related to the functional integration

Fact Sheet 9

# PROVIDER CLIENT COMMUNICATION

## Rationale

Both providers and clients identified the less-than-satisfactory quality of client–provider communication as one of the factors affecting the quality of health care provided by the municipal health services. The providers participating in the first quality assurance workshop felt that this was one aspect which efforts at facility level could change.

## Activities

- Following the first Quality Assurance Workshop (February 1998), a small group comprising primary level health care providers and WCHP representatives was formed to develop a pilot intervention for improving client–provider communication.
- Peer observation was conducted using a checklist to monitor communication and to assess the feasibility of establishing a system for routine monitoring of client–provider communication. The findings of this exercise were discussed with the participant providers (the observers and the providers observed) and feedback elicited.
- Observers and providers observed were interviewed to understand the effect of this exercise and their opinion about its usefulness. Participant providers suggested that peer observation be combined with exit interviews and third party observations.
- Participatory observation of client–provider communication at the gynaecology outpatient clinic at a secondary hospital was conducted to identify factors affecting client–provider communication. The study also explored the need for a counselling and information centre at the outpatient clinic. The findings of this study are presented in the Annex 9.1.
- The layout of the outpatient clinic was modified to facilitate a smoother patient flow and to ensure privacy. A Counselling and Information Centre was established at the outpatient clinic.
- At the gynaecology outpatient clinic, client–provider communication is regularly monitored using an observation checklist (T-9.1). A self-administered checklist was developed for clinicians (T-9.2). Pre- and

post-intervention surveys using semi-structured questionnaires were conducted to monitor client–provider communication at the gynaecology outpatient clinic at V.N. Desai Hospital (T-9.3).

- Bimonthly meetings are conducted with the staff of the gynaecology outpatient clinic and counselling centre to discuss issues and solve problems.

## Achievements

- Providers at the secondary hospital and the maternity home appreciated the feedback given by the project — they felt that the feedback made them conscious of their communication, which in turn led to desirable changes. During midterm evaluation, respondents reported that being observed resulted in improvement of communication.
- Quarterly monitoring of communication was conducted using the observation checklist.
- A Counselling and Information Centre was established at the gynaecology outpatient clinic of a secondary hospital. This will serve as a model for the MCGM.

## Constraints

- The activities listed in the preceding paragraphs aim at bringing about change in providers in terms of skills and attitudes. The complexity of the issues involved makes it difficult to ensure changes and measure the outcomes.
- Quality of communication is context-specific and hence difficult to assess. Observations and exit interviews introduce a research bias and therefore the measurements are more likely to record favourable behaviours. Using mystery clients would provide a more objective assessment but it is more difficult to organise and presents ethical problems, especially with gynaecological conditions.
- Factors such as non-availability of resources, workload, poor communication with senior administrative officials, lack of cooperation from paramedical staff, space constraints, etc., also affect client–provider communication.
- Participants in the first peer observation method did not feel comfortable observing and being observed by colleagues. 'Observation technique' requires skilled and trained individuals to conduct third party observations who could not be made available. Hence the exercise could not be repeated.

- The gap between socio-economic status and power of the providers and that of the clients poses the biggest problem in improving client–provider communication. There is a general feeling among the health care providers that the clients seeking services at the public facilities are less educated and have limited exposure to sources of information. This, providers feel, limits their ability to grasp information/explanation about their condition, leaving them unable to make the 'right' choices for themselves. At times the rights of clients seeking services at the public hospitals are ignored as they avail of services at greatly subsidised rates.

## Lessons Learnt

- Observation studies can help in identifying training needs regarding communication and form the basis for context-specific case studies that can be used for training.
- Regular monitoring is useful for keeping a check on and improving providers' communication with clients.
- Peer interviews need to be combined with exit interviews and third party interviews for better effect.
- Use of peer interviews in a hierarchical system may be difficult.
- Attitudes and prejudices emerging from the socio–economic divide between the clients and providers pose a challenge to efforts for improving client-provider communication. Sensitising health care providers to the social aspects of reproductive health conditions, to the concepts of gender, patriarchy, power relations within families and between social classes is essential for changing the quality of communication.
- In order to improve client–provider communication, it is important that factors other than the attitude and skills of doctors and nurses are identified and addressed, such as the layout of the outpatient clinic, patient flow, etc. The behaviour of cleaners and other helpers is equally important. They too need to be included in the training and review of improvements and problems encountered.

## Recommendations

- The quality of the client–provider communication can be monitored through a combination of observation and periodic exit interviews with clients. Community Development Officers can coordinate this activity on a regular basis.

- Problems in interpersonal communication between health care providers and between the heads of different facilities can affect the motivation of health care providers and their communication with clients. Administrators should play a key role in establishing an environment that is conducive to the free and effective flow of information. Apart from attitude and skills, other factors that contribute to poor communication between clients and providers such as non-availability of resources like drugs, equipment and infrastructure to ensure privacy, need to be resolved by the hospital administrators.
- Counselling and information centres should be set up at the gynaecology outpatient clinics in general hospitals. ANMs and MPWs trained in counselling skills should be placed at these centres on a rotation basis to transfer skills learned to primary services, thus reaching a maximum number of clients.
- Training programmes need to be conducted at regular intervals to sensitise health care providers to the effect of social factors and power inequalities on communication.
- Sensitising health care providers to the principles of counselling and health care needs of clients and regular follow-up and supervision of the quality of care provided is essential.

***Expected Role of Deputy Executive Health Officers (DEHOs) / Assistant Health Officers (AHOs)***

- Address issues other than communication skills that affect client–provider communication e.g., layout of the outpatient clinics.

***Expected Role of Medical Officers of Health (MOsH)***

- Ensure quarterly monitoring of communication by deputing CDOs to coordinate data collection, compilation and analysis. T-9.3 can be used for monitoring.
- Ensure that the findings of these observations are shared and discussed with the facility staff observed.

***Expected Role of Community Development Officers (CDOs)***

- Conduct counselling workshops for primary level health care providers.
- Evaluate client satisfaction by conducting and analysing exit interviews, and arrange feedback meetings with providers (T-9.3).

- Ensure placement on a rotation basis of trained ANMs/MPWs at the counselling centre.
- Function as a link between health care facilities and the MOH. Report the problems, constraints and successes of grassroots health care facilities to the MOH.

**List of Annexes**

Annex 9.1 : Salient Findings of Various Studies Conducted to Monitor Client Provider Communication

**List of Tools**

T-9.1 : Observation Checklist for Monitoring Client–Provider Communication

T-9.2 : Self-Administered Checklist for Monitoring Communication with Clients – for Doctors

T-9.3 : Exit Interviews for Assessing Client–Provider Communication — Key Questions

Annex 9.1

# Salient Findings of Various Studies Conducted to Monitor Client–Provider Communication

## 1. Exercise for monitoring the communication and assessing the feasibility of establishing a monitoring system (June 1998)

***The salient features of this exercise are***

- Development of a checklist by representatives of providers and the WCHP
- Conducting peer observation using a checklist (See T-9.1)

The exercise aimed at establishing a conducive environment for peer evaluation of communication between clients and providers. Feedback meetings with the staff helped clarify the purpose of the study.

82 episodes of clinician–patient interaction were observed. The findings are:

- Clients' information needs for diagnosis, investigations and treatment were not satisfactorily addressed:
  - 33% clients were given information about their conditions
  - 35% patients were told about the treatment in detail
  - 43% patients were give information about necessary investigations
  - For 28% patients, the doctors checked whether they had understood the information or instructions.
- Attentive listening by providers was observed in 96% episodes, as signified by providers maintaining eye contact.

In June 1999, as a part of the midterm evaluation, 13 providers who had participated in the exercise either as observers or providers being observed were interviewed to understand the effects of this exercise, as well as to get their opinion on its usefulness.

- The participants found the exercise useful in keeping a check on and improving their communication.
- Problems with the methodology of peer observation were identified. Participants suggested that peer observations need to be combined with exit interviews and third party observation, and that the context in which communication occurs needs to be recorded. Especially recording of

new / old episode, condition presented by the patient and diagnosis should be included in the analysis.

2. **Participatory observation of patient–provider communication at the gynaecology outpatient clinic of a secondary hospital**

A WCHP researcher conducted an ongoing observation exercise at the gynaecology out-patient clinic for 15 days. The purpose was to identify particularly good and bad examples of all relevant aspects of communication to develop case studies for training. Episodes were recorded verbatim and fieldnotes were kept to describe the context in which the communication took place.

***Salient Findings***

- The quality of communication varied not only from person to person but also for the same person depending on the context such as workload, communication between the doctor and the other staff at the outpatient clinic, etc.
- The socio-cultural gap between the patients and providers obstructs good communication. The language, terminology and mannerisms used by the doctors were not understood by patients and vice- versa, adversely affecting the quality of care in terms of (mis)diagnosis, compliance and informed decision-making.
- Lack of privacy and workload make it difficult for doctors to spend enough time with patients requiring counselling. Women seeking services for contraception are the worst affected.
- In order to ensure privacy, hospital policy denies spouse's entry to the gynaecology outpatient clinic. This discourages men's involvement in their wives' attempts to seek treatment, particularly in cases of STI, childlessness and contraception.
- Some providers are not sensitive to the anxiety that women, especially unmarried women and adolescent girls, experience when they undergo an examination.
- The average waiting time for patients on the examination table was observed to be 9 minutes.

T-9.1

# Observation Checklist for Monitoring Client–Provider Communication

## DURING CONSULTATION

**Place:** _____ **Post of Observer :** _____

**Time:** _____ **Post of observed:** _____

**Date:** _____

This observation checklist can be used to observe the following providers

1) FTMO - at the immunisation camp and while attending Cu-T cases

2) MO-PPC (Paediatrician) - at the paediatric outpatient clinic

3) MO-DISP - at the daily outpatient clinic

4) MO-Mat. Home - at the ANC and gynaecology outpatient clinic

5) PHN - at the immunisation camp

## DATA ABOUT CONDITION

**(Check case paper)**

A) Problem presented by patient _____

_____

B) Did the patient come for the first time with this complaint Yes No

## COMMUNICATION

1 Did the provider look at the patient when he/she entered? Yes No

2 Did the provider ask the patient to sit? Yes No

3 Was the provider seated in a way that would allow her/him to carry out physical examination of the patient and that the patient would be comfortable? Yes No

4 Was the provider polite to the accompanying person? Yes No N.A.

a) If no, how was the behaviour? _____

_____

b) Why ?

_____

_____

5 Did the provider respectfully ask the accompanying person to wait outside in cases where privacy was required? Yes No N.A.

TOOL

5a) If no, specify what happened? _____

_____

6 Did the provider address the patient by name? Yes No

7 Did the provider ask any question about the patient's complaint? Yes No

(a) If yes, what questions were asked?

_____

_____

(b) Did the provider ask her patient if he/she has anyother problems/complaints? (in addition to the current problem) Yes No N.A.

8 If the provider interrupted the patient, were the interruptions appropriate? Yes No N.A.

9a Was the provider listening in an attentive, interested way? Yes No N.A.

9b Give reasons for your answer in 9a _____

_____

10 Did the provider ask the patient whether she/he had any question? Yes No

11 Did the provider answer the question asked by the patient? Yes No N.A.

**Examination**

12 Was a physical examination done? Yes No N.A.

13 If yes, specify the nature of the examination.

_____

_____

14 Was the provider talking in a friendly and reassuring manner while conducting the examination? Yes No N.A.

**Internal Examination (Gynaec. Problems)**

15 Did the female attendant or nurse who positioned the patient for internal examination politely explain about it to the patient? Did the female attendant/nurse giving Gynaec. position explain to the patient politely? Yes No N.A.

16 Did the provider explain the PV procedure to the patient? Yes No N.A.

17 Was the patient hurriedly made to lie down? Yes No N.A.

18 Was the patient given time to prepare (untying, loosening clothes) for the examination? Yes No N.A.

TOOL

| | | | | |
|---|---|---|---|---|
| 19 | Were the legs of the patients covered with a sheet during the examination? | Yes | No | N.A. |
| 20 | Was the woman rushed into getting up from the examination table? | Yes | No | N.A. |
| 21 | After the patient was positioned for examination, how much time elapsed before the doctor examined her? | _____ minutes | | |
| 22 | Was the PV done in a careful, gentle way? (to be judged by the reactions of the patients) | Yes | No | Don't know |

**Before the Patient Leaves the Counselling Room**

| | | | | |
|---|---|---|---|---|
| 23 | Did the provider explain the | | | |
| | - Diagnosis | Yes | No | N.A. |
| | - Treatment | Yes | No | N.A. |
| | - Need and importance of investigation | Yes | No | N.A |
| 24 | Did the provider ensure that the patient had understood the instructions? | Yes | No | N.A. |
| | (a) How? | | | |

_____

| | | | | |
|---|---|---|---|---|
| 25 | Did he/she repeat the instructions if the patient had not understood them? | Yes | No | N.A. |

26 Describe any inappropriate or appropriate event that took place during the observation.

_____

_____

T-9.2

# Self- Administered Checklist for Doctors for Monitoring Communication with Client

| | | | | |
|---|---|---|---|---|
| 1. | Was the client/patient seated while she narrated her problem? | 1 Yes | 2 No | 3. Not applicable | 4. Do not know |
| 2. | Did you politely ask the accompanying person to wait outside to ensure privacy? | 1 Yes | 2 No | 3. Not applicable | 4. Do not know |
| 3. | Did you maintain eye contact/look at the woman while you asked for her history? | 1 Yes | 2 No | 3. Not applicable | 4. Do not know |
| 4. | Did you ask the patient if she had any other complaints? | 1 Yes | 2 No | 3. Not applicable | 4. Do not know |
| 5. | Did you listen to the patient without interrupting her? | 1 Yes | 2 No | 3. Not applicable | 4. Do not know |
| 6. | Did you ensure that other patients were not crowded around the table during consultation? | 1 Yes | 2 No | 3. Not applicable | 4. Do not know |
| 7. | Did the patient ask any questions? | 1 Yes | 2 No | 3. Not applicable | 4. Do not know |
| 8. | Did you answer her questions? | 1 Yes | 2 No | 3. Not applicable | 4. Do not know |
| 9. | Did you ask the patient if she had any queries? | 1 Yes | 2 No | 3. Not applicable | 4. Do not know |
| 10. | Did the patient ask any questions related to sexual relations? (if relevant) | 1 Yes | 2 No | 3. Not applicable | 4. Do not know |
| 11. | Did you ask questions related to sexual behaviour (if relevant)? | 1 Yes | 2 No | 3. Not applicable | 4. Do not know |
| 12. | Did you tell the patient about what to expect during the PV examination? | 1 Yes | 2 No | 3. Not applicable | 4. Do not know |
| 13. | Did you ensure that the nurse or attendant instructed the patient for PV examination? | 1 Yes | 2 No | 3. Not applicable | 4. Do not know |
| 14. | Did you ensure that the woman's legs were covered during the PV examination? | 1 Yes | 2 No | 3. Not applicable | 4. Do not know |
| 15. | How long did the woman wait on the examination table? Less than 5 minutes? | 1 Yes | 2 No | 3. Not applicable | 4. Do not know |
| 16. | Did you reassure the woman during the PV examination? | 1 Yes | 2 No | 3. Not applicable | 4. Do not know |
| 17. | Did you talk to the woman during PV? | 1 Yes | 2 No | 3. Not applicable | 4. Do not know |
| 18. | Did you tell the woman about the findings of PV? | 1 Yes | 2 No | 3. Not applicable | 4 Do not know |
| 19. | (For male doctor) Did you ensure that nurse/*ayabai* was present during PV examination? | 1 Yes | 2 No | 3. Not applicable | 4. Do not know |
| 20. | Did you inform the woman about the diagnosis/reason for her symptoms? | 1 Yes | 2 No | 3. Not applicable | 4. Do not know |

| | | | |
|---|---|---|---|
| 21. Did you tell her where she could buy the medicines, and the dosage and duration of medication? | 1 Yes | 2 No | 3. Not applicable | 4. Do not know |
| 22. Did you tell the client about further investigations (if any) required, the reason why they are necessary, where the client can get them done and at what cost, etc.? | 1 Yes | 2 No | 3. Not applicable | 4. Do not know |
| 23. Did you tell the client about any surgery/procedure she might require, the reason for it, when, where, expenses, etc.? | 1 Yes | 2 No | 3. Not applicable | 4. Do not know |
| 24. Did you inform the client about how she should prepare for the surgery/procedure? | 1 Yes | 2 No | 3. Not applicable | 4. Do not know |
| 25. Did you ensure that the client had understood all the instructions? Did you ask the client to repeat the instructions? | 1 Yes | 2 No | 3. Not applicable | 4. Do not know |
| 26. If the client did not understand the instructions, did you repeat them? | 1 Yes | 2 No | 3. Not applicable | 4. Do not know |
| 27. Did you advise the client about sexual relations? | 1 Yes | 2 No | 3. Not applicable | 4. Do not know |
| 28. Did you tell the client about when and if follow-up visits were required? | 1 Yes | 2 No | 3. Not applicable | 4. Do not know |
| 29. Did you shout at or insult the patient? | 1 Yes | 2 No | 3. Not applicable | 4. Do not know |
| 30. Did your frustration at any time reflect in your communication with the patient? | 1 Yes | 2 No | 3. Not applicable | 4. Do not know |

**Score** :

- **Questions 1 to 28: One mark each for 'Yes'**
- **Questions 29 and 30: One mark for 'No'**

| Total score | Rating for communication |
|---|---|
| 8 or less | Poor. Needs immediate attention. |
| 9 to 15 | Fair. Needs improvement |
| 16 to 20 | Good. Keep it up! |
| More than 20 | Very Good. You can be a role model! |

TOOL

T-9.3

# Exit Interviews for Assessing Client-Provider Communication - Key Questions

An exhaustive interview schedule was used to document effect of modifying the layout of the gynaecology outpatient clinic and the regular feedback to providers about their communication with clients at the V. N. Desai Hospital. Both pre- and post-intervention surveys were carried out using the same schedule. Key questions that brought out the difference in quality of communication that took place pre- and post- intervention are presented below. These questions can be used as markers for documenting the difference in client–provider communication following an intervention. The interview schedule was validated against observations conducted by trained observers using the observation checklist.

| Indicator | | Questions |
|---|---|---|
| **Attitude of staff towards the client** | 1. | If a nurse was present during internal examination, was she rude or polite with you? |
| | 2. | If a female attendant *(ayabai)* was present during internal examination, was she rude or polite with you? |
| | 3. | Was the doctor rude or polite with you (general interaction)? |
| | 4. | Was the nurse rude or polite with you (general interaction)? |
| | 5. | Was the female attendant *(ayabai)* rude or polite with you (general interaction)? |
| | 6. | Did the doctor shout at you? |
| | 7. | Did the doctor insult you? |
| | 8. | Did the nurse shout at you? |
| | 9. | Did the nurse insult you? |
| | 10. | Did the female attendant *(ayabai)* shout at you? |
| | 11. | Did the female attendant *(ayabai)* insult you? |
| **Trust between client and provider** | 12. | Did you feel that the doctor was listening to you attentively while you talked about your complaints? |
| | 13. | Could you answer all the questions asked by the doctor? |
| | 14. | Could you answer all the questions related to sexual relations asked by the doctor? |
| | 15. | Could you tell the doctor everything that you wanted to say about your condition? |
| | 16. | Did the doctor ask you if you had any other complaint? |
| | 17. | Could you speak freely with the doctor? |
| | 18. | Did you feel shy while talking to the doctor? |
| | 19. | Was your communication with the doctor interrupted for any reason? |
| | 20. | Could you ask questions about sexual relations? |
| | 21. | Did the doctor answer your questions about sexual relations? |
| **Assistance to client to relax during PV** | 22. | Did the doctor tell you to relax during internal examination? |
| | 23. | Did the doctor do anything to lessen your fear during internal examination? |
| **Reassurance** | 24. | Did the doctor say 'Don't worry, it won't hurt', etc., during the internal examination? |
| | 25. | Did the doctor talk to you during internal examination? |

TOOL

| | | |
|---|---|---|
| **Information** | 26. | Did the doctor tell you what s/he found from PV examination? |
| | 27. | Did the doctor inform you about the diagnosis or reason for your symptoms? |
| | 28. | What did the doctor tell you about MTP/FP? |
| | 29. | Did you understand the information given to you? |
| | 30. | Did the doctor confirm that you understood the information given to you? |
| | 31. | Can you tell me from where you were asked to get these medicines? How and for how many days are you expected to take them? |
| | 32. | Did the doctor ask you to repeat his/her instructions? |
| | 33. | What investigations did the doctor advise you to get done? |
| | 34. | Can you tell me why you were told to get these investigations done? |
| | 35. | Where will you get these investigations done? |
| | 36. | Did the doctor tell you how much the investigations would cost? |
| **Privacy** | 37. | Were other patients standing around the table while you were talking to the doctor? |
| | 38. | Was your communication with the doctor interrupted because the examining doctor was speaking to some other doctor? |
| | 39. | Was your communication with the doctor interrupted because the examining doctor was speaking to some other patient? |
| | 40. | Was your communication with the doctor interrupted because the examining doctor speaking to some other people like medical representatives or friends? |
| | 41. | Were you given enough time to undress? |
| | 42. | Was there enough privacy for undressing? |
| | 43. | Was there privacy during PV examination? |
| | 44. | Did you think that the women sitting on the bench could see you while you underwent the PV examination? |
| | 45. | Were your legs covered during the PV examination? |
| | 46. | Did you have to wait on the examination table for more than 5 minutes? |

Fact Sheet 10

# INITIATING A COUNSELLING CENTRE IN A GYNAECOLOGY CLINIC

## Rationale

Empowering clients to understand their health condition and make relevant decisions with reference to it is an important component of quality health care services. In its efforts to improve the quality of reproductive health care provided by the health care facilities of the Public Health Department of the Mumbai Municipal Corporation, the project explored the issue of information provided to clients.

An unmet need for information and counselling was revealed by a number of studies. Women interviewed for an earlier study on Pelvic Inflammatory Diseases (PID) expressed the need for information on reproductive health problems for self and partners. They wanted their male partners to take responsibility regarding contraception and prevention of STDs. They also expressed the need for counselling services for both partners. Interviews with men in the community revealed that they had limited information about women's reproductive system and expressed the need to know more.

Observations at the gynaecology outpatient clinic of a secondary hospital and discussions with the health care providers identified a number of factors that affect client–provider communication and the extent of information given to clients by health care providers. Important among these are class differences between clients and providers, providers' attitude towards poor and illiterate clients — particularly their belief that these women are not capable of understanding information and making decisions for themselves — and the pressure on them to meet family planning targets. Other factors affecting the amount of time doctors spend with each client are heavy workload at the outpatient clinic, stressful working conditions, lack of coordination between the outpatient clinic staff members, language barriers and the arrogance of some patients.

In a large number of instances it was observed that socio–cultural differences between clients and providers prevented clients from asking for clarifications, thereby leaving their information needs unattended. The doctors acknowledged the need for counselling and suggested that counselling services be provided

as part of the services offered by the gynaecology outpatient clinic.

In response to this need, a counselling centre was established at the Gynaecology OutPatient Department of a secondary hospital.

## Activities

- Layout of the outpatient clinic was modified to streamline patient flow and accommodate the counselling centre inside the gynaecology outpatient clinic. The renovation also helped to create a pleasant work environment. A token system was introduced to reduce waiting time for clients. All changes were made in consultation with medical, paramedical and non-medical staff at the gynaecology outpatient clinic.
- A separate space outside the outpatient clinic was allotted for counselling men.
- A training module for counselling was developed by consulting clinicians, counsellors, psychologists, social workers, women's rights' activists and health management specialists to include gender, reproductive rights, counselling for violence survivors, sexuality issues and adolescent counselling skills.
- Using this module, ANMs and MPWs from health posts were trained in basic counselling and communication skills, gender sensitivity and sexuality issues. They were provided with basic technical knowledge on medical termination of pregnancy, hysterectomy, contraception, reproductive tract infections and other conditions commonly seen at the outpatient clinic. The trained ANMs and MPWs were then placed at the centre to offer counselling services to clients under the supervision of a trained counsellor.
- The quality of counselling provided by these ANMs and MPWs was regularly assessed using a checklist (T-10.1). Checklists have also been developed for monitoring the counselling provided for MTP and contraception, menstrual disorders, major surgery and reproductive tract infections (T-10.2, T-10.3, T-10.4, T-10.5).
- General information like the timings and locations of various outpatient clinics in the hospital is displayed at the gynaecology outpatient clinic.
- Detailed face sheets (formats used to record detailed information about the client) and case records of men and women clients are maintained at the counselling centre and analysed every month to identify

reproductive rights issues. Emerging issues are discussed with doctors to ensure that the rights of clients are not violated. Case presentation meetings are held with the doctors every two months.

- A bimonthly staff meeting is conducted by the honorary clinician to discuss issues relating to the quality of the services offered and the problems encountered, and to arrive at solutions agreeable to the team.
- A suggestion box has been installed at the outpatient clinic to enable staff and clients to give their feedback on the quality of service (both medical and counselling) and problems encountered, if any.
- Every new batch of resident doctors is oriented to the concepts of quality of care, reproductive rights and their role vis-à-vis the counselling centre (T-10.6).
- Doctors and paramedical staff are sensitised to the concept of reproductive rights through ongoing training programmes and advocacy workshops.
- Client–provider communication is observed and feedback is given to the providers on a regular basis to sensitise them to client-friendly communication practices.

## Achievements

- Since the initiation of counselling services (January 2002 till November 2003), rotational teams comprising a trained counseller and two ANMs and one MPW trained in basic counselling skills have provided counselling services to 350 women and 200 men through the centre.
- Basic counselling services by paramedical staff have been successful in meeting information and counselling needs relating to contraceptive choices, complications, etc.
- Conflicts between doctors and counsellors have been reduced by sensitising the doctors to the principles of counselling and discussing issues on a regular basis.
- The staff at the outpatient clinic discuss and acknowledg the reproductive rights of women and the responsibilities of patients in seeking treatment. The job descriptions of each category of staff were reviewed and modified where necessary to ensure quality reproductive care to clients. Reproductive rights, patients' responsibilities and job descriptions for all

categories of staff are displayed in the outpatient clinic for better accountability.

- Clients have become regular about their follow-up visits and some have been visiting the counselling centre to seek help for social issues relating to their health problem(s).
- The centre provides a safe and open environment amidst the formal set up of the outpatient clinic, thus encouraging women to think through their decisions.
- Feedback to providers on client–provider communication has made them aware of the importance of improving their communication skills and dealing with women patients with sensitivity and care.

## Constraints

- Sometimes doctors find it difficult to accept that clients have a right to choose a contraceptive method and this results in conflict between the counsellor and the doctors.
- Target-based population control policies prevent health care providers from being sensitive and offering needs-based contraceptive services to couples.
- Frequent rotation of staff at the outpatient clinic — every six months for resident medical officers (RMOs) and every year for nurses and attendants — breaks the continuity of the efforts. It is therefore essential to be ready to repeat the process of orientation and perspective building at short intervals.

## Lessons Learnt

- ANMs and MPWs are required to address many sensitive issues during counselling, which can put them under a great deal of stress. Forums for sharing their concerns, de-stressing and providing refresher sessions on counselling skills need to be created and sustained.
- Models, flip charts and information leaflets are essential to support health providers, especially the ANMs and MPWs, in providing information to clients.
- National policies with a focus on population control rather than reproductive health pose a challenge for the implementation of a reproductive rights agenda in a public health system.

- The long-term sustainability and success of such initiatives depends on administrative support and change in the attitudes of health care providers.

**Recommendations**

- Honorary clinicians at the gynaecology outpatient clinic and the hospital social worker need to take responsibility for orienting every batch of RMOs to quality of services, importance of communication with patients, reproductive rights and gender sensitivity.
- Hospital social workers should conduct sensitivity training for all nurses and attendants.
- Health workers in the peripheral primary health care centres, i.e., health posts and dispensaries, should offer counselling services at the gynaecology outpatient clinic of their respective health care facility. The quality of their counselling should be monitored by a trained counsellor/ psychologist or social worker based at the hospital.
- Make IEC materials developed for the counselling centre available in all health posts and dispensaries.

***Expected Role of Chief Medical Superintendent (CMS)***

- Review the benefits of the model Information and Counselling Centre set up by the project and assess the feasibility of replicating it in other hospitals.
- Explore the possibilities of actively involving the representatives of nursing staff in the counselling centre.

***Expected Role of Deputy Executive Health Officers (DEHOs)/ Assistant Health Officers (AHOs)***

- Arrange counselling training at regular intervals for auxiliary nurse midwives (ANMs), male multi-purpose workers (MPWs), community development officers (CDOs) and representatives of the medical and paramedical staff from peripheral hospitals.
- Identify sustainable mechanisms for placement of trained ANMs and MPWs — either permanently or on a rotation basis — at the counselling centres in secondary hospitals.

***Expected Role of Medical Officers Of Health (MOsH)***

- Ensure counselling services at health posts and dispensaries. Create an enabling environment for the provision of such services.

***Expected Role of Community Development Officers (CDOs)***

- Participate in the counselling training.
- Organise counselling training for health care providers from health posts and dispensaries.
- Monitor counselling activities at health posts, dispensaries and at counselling centres associated with gynaecology departments of maternity homes and secondary hospitals.

## Resources required for establishing a Counselling Centre at the Gynaecology Outpatient Clinic

| Contribution by MCGM | Contribution by the project |
|---|---|
| • Venue<br>• Support staff<br>• Issuing circulars for bimonthly staff meeting | • Changed layout of three rooms to facilitate patient flow<br>• Purchase of furniture for the outpatient clinic as well as counselling centre to ensure that there is no over-crowding at the doctor's table<br>• Trained social worker to train health care providers, and for supervision and monitoring<br>• One project ANM to staff the counselling centre<br>• Supervision and guidance by CDO placed with the project<br>• Honorarium to honorary gynaecologist for conducting bimonthly meetings<br>• Writing minutes of the meetings<br>(Approximate expenditure for establishing the counselling centre was Rs 100,000). |

## List of Tools

T-10.1 : Checklist for Assessing Quality of Counselling

T-10.2 : Observation Checklist for Monitoring MTP and Contraception Counselling

T-10.3 : Observation Checklist for Monitoring Counselling for Menstrual Disorders

T-10.4 : Observation Checklist for Monitoring Counselling for Major Surgery

T-10.5 : Orientation Package to Sensitise Resident Medical Officers to the Importance of Counselling

T-10.1

# Checklist for Assessing Quality of Counselling

| | | | | | |
|---|---|---|---|---|---|
| 1. | Did the counsellor ask the client to take a seat? Was the client seated? | 1 Yes | 2 No | 3. Not applicable | 4. Do not know |
| 2. | Did the counsellor explain what the client should expect from the session? | 1 Yes | 2 No | 3. Not applicable | 4. Do not know |
| 3. | Did the counsellor assure the client that the discussion would be kept confidential and not shared with anyone else? | 1 Yes | 2 No | 3. Not applicable | 4. Do not know |
| 4. | Was the accompanying person politely asked to wait outside if privacy was required? | 1 Yes | 2 No | 3. Not applicable | 4. Do not know |
| 5. | Did the counsellor enquire about client's past illnesses/ treatment/investigations? | 1 Yes | 2 No | 3. Not applicable | 4. Do not know |
| 6. | Did the counsellor listen to the client without interrupting her/him? | 1 Yes | 2 No | 3. Not applicable | 4. Do not know |
| 7. | Did the counsellor listen attentively to the client? | 1 Yes | 2 No | 3. Not applicable | 4. Do not know |
| 8. | Did the counsellor ensure that s/he understood correctly what the client had to say? | 1 Yes | 2 No | 3. Not applicable | 4. Do not know |
| 9. | Did the counsellor paraphrase what client had said? | 1 Yes | 2 No | 3. Not applicable | 4. Do not know |
| 10. | In case of discrepancies in the client's narrative, did the counsellor clarify them with the client? | 1 Yes | 2 No | 3. Not applicable | 4. Do not know |
| 11. | Did the counsellor answer the questions asked by the client? | 1 Yes | 2 No | 3. Not applicable | 4. Do not know |
| 12. | Did the counsellor ask the client if s/he had any questions? | 1 Yes | 2 No | 3. Not applicable | 4. Do not know |
| 13. | Did the client ask any questions? | 1 Yes | 2 No | 3. Not applicable | 4. Do not know |
| 14. | Did the counsellor answer questions asked by the client ? | 1 Yes | 2 No | 3 Not applicable | 4. Do not know |
| 15. | Did the client ask any questions related to sexual relations? | 1 Yes | 2 No | 3. Not applicable | 4. Do not know |
| 16. | Did the counsellor answer questions asked by the client regarding sexual relations? | 1 Yes | 2 No | 3. Not applicable | 4. Do not know |
| 17. | Did the counsellor give information regarding investigations prescribed, reason for doing the investigations, where to get them done, and the costs involved? | 1 Yes | 2 No | 3. Not applicable | 4. Do not know |
| 18. | Did the counsellor give information regarding surgery/ procedure advised, the reason for it, where to get it done and what it would cost, and the procedure followed during surgery? | 1 Yes | 2 No | 3. Not applicable | 4. Do not know |
| 19. | Did the counsellor instruct the client about how to prepare for the surgery/procedure? | 1 Yes | 2 No | 3. Not applicable | 4. Do not know |

TOOL

| | | | | |
|---|---|---|---|---|
| 20. | Did the counsellor explain the admission procedure to the client? | 1 Yes | 2 No | 3. Not applicable | 4. Do not know |
| 21. | Did the counsellor ensure that the client understood the information given to her/him? | 1 Yes | 2 No | 3. Not applicable | 4. Do not know |
| 22. | Was the client asked to repeat the instructions? | 1 Yes | 2 No | 3. Not applicable | 4. Do not know |
| 23. | Did the counsellor encourage client to speak? | 1 Yes | 2 No | 3. Not applicable | 4. Do not know |
| 24. | Did the counsellor ask the client to say what s/he thought/ knew about the situation/condition before giving information? | 1 Yes | 2 No | 3. Not applicable | 4. Do not know |
| 25. | Did the counsellor ask open questions? Did the counsellor probe where required? | 1 Yes | 2 No | 3. Not applicable | 4. Do not know |
| 26. | Did the counsellor modulate her/his voice while speaking to the client? | 1 Yes | 2 No | 3. Not applicable | 4. Do not know |
| 27. | Did the counsellor use technical words while giving information? | 1 Yes | 2 No | 3. Not applicable | 4. Do not know |
| 28. | Were the counsellor's expressions responsive to the emotions expressed by the client? | 1 Yes | 2 No | 3. Not applicable | 4. Do not know |
| 29. | Did the counsellor pause at appropriate times during the counselling session? | 1 Yes | 2 No | 3. Not applicable | 4. Do not know |
| 30. | Did the counsellor reassure the client? | 1 Yes | 2 No | 3. Not applicable | 4. Do not know |
| 31. | Did the counsellor help the client focus on the important issues at hand? | 1 Yes | 2 No | 3. Not applicable | 4. Do not know |
| 32. | Did the counsellor listen to the client without being critical or judgemental? | 1 Yes | 2 No | 3. Not applicable | 4. Do not know |
| 33. | Did the counsellor use IEC material to give information? | 1 Yes | 2 No | 3. Not applicable | 4. Do not know |
| 34. | At the end of the session, did the counsellor summarise the issues discussed? | 1 Yes | 2 No | 3. Not applicable | 4. Do not know |
| 35. | Did the counsellor tell the client about follow-up: whether required, when, etc.? | 1 Yes | 2 No | 3. Not applicable | 4. Do not know |
| 36. | Did the counsellor smile (if appropriate) at the end of the session? | 1 Yes | 2 No | 3. Not applicable | 4. Do not know |

T-10. 2

# Observation Checklist for MTP and Contraception Counselling

**Name of the observer** **Client number**

**Date** **Time**

*For each question, please circle the appropriate option.*

| | | | | | |
|---|---|---|---|---|---|
| 1. | Did the counsellor ask the date of the last menstrual period? | 1. Yes | 2. No | 3. Not applicable | 4. Do not know |
| 2. | Did the counsellor take the history of number of children, pregnancies, abortions/MTPs? | 1. Yes | 2. No | 3. Not applicable | 4. Do not know |
| 3. | Did the counsellor discuss in detail the reasons for aborting present pregnancy? | 1. Yes | 2. No | 3. Not applicable | 4. Do not know |
| 4. | Did the counsellor ask if clients' husband has accompanied her? | 1. Yes | 2. No | 3. Not applicable | 4. Do not know |
| 4.1 | Did the counsellor ask the client if she would like to invite the husband inside? | 1. Yes | 2. No | 3. Not applicable | 4. Do not know |
| 4.2 | Did the counsellor ask the husband to come inside if the client so wished ? | 1. Yes | 2. No | 3. Not applicable | 4. Do not know |
| 5. | Did the counsellor ask the client if she knew how MTP was done? | 1. Yes | 2. No | 3. Not applicable | 4. Do not know |
| 5.1 | If the client knew about the methods of MTP, did the counsellor ask her to share the information? | 1. Yes | 2. No | 3. Not applicable | 4. Do not know |
| 5.2 | If client did not have complete information, did the counsellor explain how MTP is done? | 1. Yes | 2. No | 3. Not applicable | 4. Do not know |
| 6. | After she gave this information, did the counsellor ask the client if she wanted an MTP? | 1. Yes | 2. No | 3. Not applicable | 4. Do not know |
| 7. | Did the counsellor then explain the risks associated with MTP? | 1. Yes | 2. No | 3. Not applicable | 4. Do not know |
| 8. | Did the counsellor allow the client some time to think about her decision? | 1. Yes | 2. No | 3. Not applicable | 4. Do not know |
| 8.1 | Did the counsellor ask the client if she wanted to go out of the centre to think and make a decision? | 1. Yes | 2. No | 3. Not applicable | 4. Do not know |
| 9. | Did the counsellor ask the client if she still wanted to have an MTP after she had reviewed all the information given to her? | 1. Yes | 2. No | 3. Not applicable | 4. Do not know |
| 10. | Did the counsellor inform the client that at times MTP results in incomplete evacuation of the contents of the uterus? | 1. Yes | 2. No | 3. Not applicable | 4. Do not know |
| 11. | Did the counsellor ask the client about her plans to prevent a pregnancy immediately after the MTP? Did the counsellor ask if the client knew of spacing methods? | 1. Yes | 2. No | 3. Not applicable | 4. Do not know |
| 12. | Did the counsellor ask the client if she knew about the process of conception? | 1. Yes | 2. No | 3. Not applicable | 4. Do not know |
| 12.1 | If the client did not know this, did the counsellor give her the relevant information? | 1. Yes | 2. No | 3. Not applicable | 4. Do not know |

| | | | | | |
|---|---|---|---|---|---|
| 13. | Did the counsellor ask if the client had used any contraceptive/spacing method in the past? | 1. Yes | 2. No | 3. Not applicable | 4. Do not know |
| 13.1 | If the client had used some method, did the counsellor encourage her to discuss it? | 1. Yes | 2. No | 3. Not applicable | 4. Do not know |
| 14. | If the client did not know about contraceptives, did the counsellor ask if she wanted more children? | 1. Yes | 2. No | 3. Not applicable | 4. Do not know |
| 15. | If client wanted more children, did the counsellor give information about reversible/temporary contraceptives as per the checklist given below? | 1. Yes | 2. No | 3. Not applicable | 4. Do not know |
| **15.1** | **Oral Contraceptive Pills (OCP)** | | | | |
| 15.1.1 | Did the counsellor ask the client what she knew about OCPs or what she has heard about OCPs? | 1. Yes | 2. No | 3. Not applicable | 4. Do not know |
| 15.1.2 | Did the counsellor address misconceptions if any? | 1. Yes | 2. No | 3. Not applicable | 4. Do not know |
| 15.1.3 | Did the counsellor explain the function of OCPs? | 1. Yes | 2. No | 3. Not applicable | 4. Do not know |
| 15.1.4 | Did the counsellor explain the benefits of OCPs? | 1. Yes | 2. No | 3. Not applicable | 4. Do not know |
| 15.1.5 | Did the counsellor explain the side effects of OCPs? | 1. Yes | 2. No | 3. Not applicable | 4. Do not know |
| 15.1.6 | Did the counsellor explain who can use OCPs and who cannot? | 1. Yes | 2. No | 3. Not applicable | 4. Do not know |
| 15.1.7 | Did the counsellor explain how to use OCPs, at least briefly? | 1. Yes | 2. No | 3. Not applicable | 4. Do not know |
| **15.2** | **Condom** | | | | |
| 15.2.1 | Did the counsellor ask the client what she knew about condoms or what she has heard about condoms? | 1. Yes | 2. No | 3. Not applicable | 4. Do not know |
| 15.2.2 | Did the counsellor address misconceptions if any? | 1. Yes | 2. No | 3. Not applicable | 4. Do not know |
| 15.2.3 | Did the counsellor discuss who should use the condom and when? | 1. Yes | 2. No | 3. Not applicable | 4. Do not know |
| 15.2.4 | Did the counsellor explain how the condom functions as a contraceptive? | 1. Yes | 2. No | 3. Not applicable | 4. Do not know |
| 15.2.5 | Did the counsellor explain the advantages of using condom? | 1. Yes | 2. No | 3. Not applicable | 4. Do not know |
| 15.2.6 | Did the counsellor explain the disadvantages of condom use? | 1. Yes | 2. No | 3. Not applicable | 4. Do not know |
| 15.2.7 | Did the counsellor explain how to use a condom? (If male partner had accompanied the client, was he called inside and explained about condom use?) | 1. Yes | 2. No | 3. Not applicable | 4. Do not know |
| 15.2.8 | Did the counsellor demonstrate how to use condom? | 1. Yes | 2. No | 3. Not applicable | 4. Do not know |
| **15.3** | **Copper T (CuT)** | | | | |
| 15.3.1 | Did the counsellor ask the client what she knew or had heard about CuT? | 1. Yes | 2. No | 3. Not applicable | 4. Do not know |
| 15.3.2 | Did the counsellor address misconceptions if any? | 1. Yes | 2. No | 3. Not applicable | 4. Do not know |
| 15.3.3 | Did the counsellor explain how the CuT functions as a contraceptive? | 1. Yes | 2. No | 3. Not applicable | 4. Do not know |
| 15.3.4 | Did the counsellor tell the client when the CuT should be inserted? | 1. Yes | 2. No | 3. Not applicable | 4. Do not know |

| | | | | | |
|---|---|---|---|---|---|
| 15.3.5 | Did the counsellor explain the advantages of CuT? | 1. Yes | 2. No | 3. Not applicable | 4. Do not know |
| 15.3.6 | Did the counsellor discuss the disadvantages of CuT? | 1. Yes | 2. No | 3. Not applicable | 4. Do not know |
| 15.3.7 | Did the counsellor discuss which women should and which women should not use CuT? | 1. Yes | 2. No | 3. Not applicable | 4. Do not know |
| 15.3.8 | Did the counsellor ask if the client had any symptoms of RTI? | 1. Yes | 2. No | 3. Not applicable | 4. Do not know |
| 15.3.9 | If the client reported symptoms of RTI, did the counsellor advise her not to insert CuT immediately and discuss about intercourse? | 1. Yes | 2. No | 3. Not applicable | 4. Do not know |
| 15.3.10 | Did the counsellor demonstrate how the CuT is inserted? | 1. Yes | 2. No | 3. Not applicable | 4. Do not know |
| 16. | If the client did not want more children after MTP, did the counsellor give her information on permanent methods of contraception as per the checklist given below | 1. Yes | 2. No | 3. Not applicable | 4. Do not know |
| 16.1 | **Female Sterilisation** | | | | |
| 16.1.1 | Did the counsellor ask the client if she knew or had heard anything about female sterilisation? | 1. Yes | 2. No | 3. Not applicable | 4. Do not know |
| 16.1.2 | Did the counsellor address misconceptions if any? | 1. Yes | 2. No | 3. Not applicable | 4. Do not know |
| 16.1.3 | Did the counsellor tell the client that this is a permanent method and the woman will not be able to conceive after this? | 1. Yes | 2. No | 3. Not applicable | 4. Do not know |
| 16.1.4 | Did the counsellor explain reasons for inability to conceive after sterilisation ? | 1. Yes | 2. No | 3. Not applicable | 4. Do not know |
| 16.1.5 | Did the counsellor tell the client when this surgery should be performed? | 1. Yes | 2. No | 3. Not applicable | 4. Do not know |
| 16.1.6 | Did the counsellor discuss the advantages of female sterilisation? | 1. Yes | 2. No | 3. Not applicable | 4. Do not know |
| 16.1.7 | Did the counsellor discuss the disadvantages of such sterilisation? | 1. Yes | 2. No | 3. Not applicable | 4. Do not know |
| 16.1.8 | Did the counsellor inform the woman about the required length of stay at the hospital following surgery? | 1. Yes | 2. No | 3. Not applicable | 4. Do not know |
| 16.1.9 | Did the counsellor tell the client about the duration of rest required to be taken after sterilisation surgery? | 1. Yes | 2. No | 3. Not applicable | 4. Do not know |
| 16.1.10 | Did the counsellor explain the surgical procedure? | 1. Yes | 2. No | 3. Not applicable | 4. Do not know |
| 16.1.11 | Did the counsellor tell the client where to go for the surgery? | 1. Yes | 2. No | 3. Not applicable | 4. Do not know |
| 16.1.12 | Did the counsellor discuss the possibility of failure of the surgery? | 1. Yes | 2. No | 3. Not applicable | 4. Do not know |
| **16.2** | **Male sterilisation** | | | | |
| 16.2.1 | Did the counsellor ask the client if she knew or had heard anything about male sterilisation? | 1. Yes | 2. No | 3. Not applicable | 4. Do not know |
| 16.2.2 | Did the counsellor address misconceptions if any? | 1. Yes | 2. No | 3. Not applicable | 4. Do not know |
| 16.2.3 | Did the counsellor explain that this is a permanent method and the woman will not be able to conceive after this? | 1. Yes | 2. No | 3. Not applicable | 4. Do not know |

| | | | | | |
|---|---|---|---|---|---|
| 16.2..4 | Did the counsellor explain the reasons for inability to conceive after the operation? | 1. Yes | 2. No | 3. Not applicable | 4. Do not know |
| 16.2.5 | Did the counsellor discuss the advantages of male sterilisation? | 1. Yes | 2. No | 3. Not applicable | 4. Do not know |
| 16.2.6 | Did the counsellor discuss disadvantages of male sterilisation? | 1. Yes | 2. No | 3. Not applicable | 4. Do not know |
| 16.2.7 | Did the counsellor tell the client about the required length of stay in the hospital after the surgery? | 1. Yes | 2. No | 3. Not applicable | 4. Do not know |
| 16.2.8 | Did the counsellor say anything about the number of days that the man will be required to rest after sterilisation? | 1. Yes | 2. No | 3. Not applicable | 4. Do not know |
| 16.2.9 | Did the counsellor explain about when this surgery should be performed? | 1. Yes | 2. No | 3. Not applicable | 4. Do not know |
| 16.2.10 | Did the counsellor explain surgical procedure? | 1. Yes | 2. No | 3. Not applicable | 4. Do not know |
| 16.2.11 | Did the counsellor discuss the possibility of failure of the surgery? | 1. Yes | 2. No | 3. Not applicable | 4. Do not know |
| 17. | Did the counsellor ask the client which of the aforementioned methods she wanted to adopt? | 1. Yes | 2. No | 3. Not applicable | 4. Do not know |
| 18. | If the client made a decision, did the counsellor explain that it was important to inform the client's husband of this decision? | 1. Yes | 2. No | 3. Not applicable | 4. Do not know |
| 18.1 | If the client agreed, did the counsellor give all the information to the client's husband? | 1. Yes | 2. No | 3. Not applicable | 4. Do not know |
| 18.2 | Did the counsellor start the discussion with male sterilisation? | 1. Yes | 2. No | 3. Not applicable | 4. Do not know |
| 18.3 | Did the counsellor inform the client and her husband about temporary methods? | 1. Yes | 2. No | 3. Not applicable | 4. Do not know |
| 18.4 | Did the counsellor inform the client and her husband about permanent methods? | 1. Yes | 2. No | 3. Not applicable | 4. Do not know |
| 19. | Did the counsellor ask the husband which method the couple would prefer? | 1. Yes | 2. No | 3. Not applicable | 4. Do not know |
| 19.1 | Did the counsellor ask the husband's opinion on the method preferred by the client? | 1. Yes | 2. No | 3. Not applicable | 4. Do not know |
| 20. | Did the counsellor allow them time to think before taking a decision? | 1. Yes | 2. No | 3. Not applicable | 4. Do not know |
| 21. | Did the counsellor repeat the information for the method selected by the couple? | 1. Yes | 2. No | 3. Not applicable | 4. Do not know |
| 21.1 | If required, did the counsellor give detailed information about the method selected by the couple? | 1. Yes | 2. No | 3. Not applicable | 4. Do not know |
| 21.2 | Did the counsellor give the client/husband the date and time for admission? | 1. Yes | 2. No | 3. Not applicable | 4. Do not know |
| 22. | If no decision was taken, did the counsellor fix another appointment? | 1. Yes | 2. No | 3. Not applicable | 4. Do not know |
| 23. | Did the counsellor tell the client that she could refer other women to the counselling centre for information on contraception and other reproductive conditions? | 1. Yes | 2. No | 3. Not applicable | 4. Do not know |
| 24. | Did the counsellor smile at the end of the session? | 1. Yes | 2. No | 3. Not applicable | 4. Do not know |

T-10. 3

# Observation Checklist for Monitoring Counselling for Menstrual Disorders

**Name of the observer** **Client number**

**Date** **Time**

*For each question, please circle the appropriate option.*

| | | | | | |
|---|---|---|---|---|---|
| **1. Assuring confidentiality:** Did the counsellor | | | | | |
| 1.1 | tell the client that the discussion in the session will be kept confidential? | 1. Yes | 2. No | 3. Not applicable | 4. Do not know |
| **2 . Involving accompanying person in the counselling session** | | | | | |
| 2.1 | If the woman was accompanied by a partner/relative, was the accompanying person invited into the counselling centre if the client desired? (together or separately) | 1. Yes | 2. No | 3. Not applicable | 4. Do not know |
| **3. Description of the current problem/Exploring facts:** Did the counsellor | | | | | |
| 3.1 | ask the client about her problem in detail using open-ended questions? (symptoms, since when, details about menstrual cycle, whether taken any treatment before coming to the hospital, any associated probable causes and so on) | 1. Yes | 2. No | 3. Not applicable | 4. Do not know |
| 3.2 | explore whether the patient has any other psychological or family problems or tension? | 1. Yes | 2. No | 3. Not applicable | 4. Do not know |
| 3.3 | explore the food habits and diet of the patient? | 1. Yes | 2. No | 3. Not applicable | 4. Do not know |
| 3.4 | see all reports and papers? | 1. Yes | 2. No | 3. Not applicable | 4. Do not know |
| **4. Exploring client's understanding about her problem:** Did the counsellor | | | | | |
| 4.1 | ask the client to explain what she knew about the treatment/investigations advised by the doctor? | 1. Yes | 2. No | 3. Not applicable | 4. Do not know |
| **5. Giving information:** Did the counsellor provide information about | | | | | |
| 5.1 | anatomy and physiology of menstrual cycle? | 1. Yes | 2. No | 3. Not applicable | 4. Do not know |
| 5.2 | how the brain controls the hormone level which affects the menstrual cycle? | 1. Yes | 2. No | 3. Not applicable | 4. Do not know |
| 5.3 | the probable causes of irregular menstruation? | 1. Yes | 2. No | 3. Not applicable | 4. Do not know |
| 5.4 | the importance of investigations? | 1. Yes | 2. No | 3. Not applicable | 4. Do not know |
| 5.5 | the importance of a balanced diet? | 1. Yes | 2. No | 3. Not applicable | 4. Do not know |
| 5.6 | the importance of completing the course of medicines prescribed? | 1. Yes | 2. No | 3. Not applicable | 4. Do not know |
| 5.7 | the importance of follow-up visits? | 1. Yes | 2. No | 3. Not applicable | 4. Do not know |

| | | | | | |
|---|---|---|---|---|---|
| **6. Giving reassurance** | | | | | |
| 6.1 | Did the counsellor reassure the client, telling her that the investigations and treatment may take time and that she should not become impatient? | 1. Yes | 2. No | 3. Not applicable | 4. Do not anow |
| **7. Information on men's responsibility to the partner:** Did the counsellor provide information on | | | | | |
| 7.1 | the anatomy and physiology of the menstrual cycle? | 1. Yes | 2. No | 3. Not applicable | 4. Do not know |
| 7.2 | how the brain controls the hormone levels which affect the menstrual cycle? | 1. Yes | 2. No | 3. Not applicable | 4. Do not know |
| 7.3 | the probable causes of irregular menstruation? | 1. Yes | 2. No | 3. Not applicable | 4. Do not know |
| 7.4 | the importance of investigations? | 1. Yes | 2. No | 3. Not applicable | 4. Do not know |
| 7.5 | the importance of a balanced diet? | 1. Yes | 2. No | 3. Not applicable | 4. Do not know |
| 7.6 | the importance of completing the course of medicines prescribed? | 1. Yes | 2. No | 3. Not applicable | 4. Do not know |
| 7.7 | the fact that investigations and treatment may take some time and therefore the need for patience? | 1. Yes | 2. No | 3. Not applicable | 4. Do not know |
| 7.8 | the importance of follow-up visits? | 1. Yes | 2. No | 3. Not applicable | 4. Do not know |
| **8. Encouraging clients to ask questions and share difficulties:** Did the counsellor | | | | | |
| 8.1 | ask if the client had any queries or doubts? | 1. Yes | 2. No | 3. Not applicable | 4. Do not know |
| 8.2 | answer the questions raised? | 1. Yes | 2. No | 3. Not applicable | 4. Do not know |
| 8.3 | ask the client if she had any difficulties regarding treatment or investigations? | 1. Yes | 2. No | 3. Not applicable | 4. Do not know |
| 8.4 | (If the client had any difficulties) discuss the problems and suggest ways of overcoming them? | 1. Yes | 2. No | 3. Not applicable | 4. Do not know |
| **9. Confirming whether the information given is understood by the client before she/he leaves:** Did the counsellor | | | | | |
| 9.1 | ask the client whether she had any doubts or queries regarding the information given? | 1. Yes | 2. No | 3. Not applicable | 4. Do not know |
| 9.2 | ask her to repeat the key points of the information provided? | 1. Yes | 2. No | 3. Not kpplicable | 4. Do not know |
| 9.3 | ask the client to repeat the date fixed for follow-up visit? | 1. Yes | 2. No | 3. Not applicable | 4. Do not know |

T-10. 4

# Observation Checklist for Monitoring Counselling for Major Surgery

**Name of the observer** **Client number**

**Date** **Time**

*For each question, please circle the appropriate option.*

| | | | | | |
|---|---|---|---|---|---|
| **1. Involving accompanying person in the counselling session** | | | | | |
| 1.1 | If women is accompanied by a relative/friend, was the accompanying person invited into the counseling centre if the client so desired? | 1. Yes | 2. No | 3. Not applicable | 4. Do not kKnow |
| **2. Discussing the current problem:** Did the counsellor | | | | | |
| 2.1 | ask the client about her problem in detail? | 1. Yes | 2. No | 3. Not applicable | 4. Do not know |
| 2.2 | see all reports and papers? | 1. Yes | 2. No | 3. Not applicable | 4. Do not know |
| **3. Exploring women's understanding about their problem:** Did the counsellor | | | | | |
| 3.1. | ask the client if she knew what the report said and whether she understood the information given by the doctor? | 1. Yes | 2. No | 3. Not applicable | 4. Do not know |
| 3.2 | ask the client what she knew about the surgery advised? | 1. Yes | 2. No | 3. Not applicable | 4. Do not know |
| **4. Giving Information:** Did the counsellor provide the following information | | | | | |
| 4.1 | **About surgery and pre-operative preparation** | | | | |
| 4.1.1 | the nature of the surgery and how it is performed | 1. Yes | 2. No | 3. Not applicable | 4. Do not know |
| 4.1.2 | preparation for the surgery as advised by the doctor | 1. Yes | 2. No | 3. Not applicable | 4. Do not know |
| 4.1.3 | investigations to be done | 1. Yes | 2. No | 3. Not applicable | 4. Do not know |
| 4.1.4 | procedure for admission to the hospital | 1. Yes | 2. No | 3. Not applicable | 4. Do not know |
| 4.1.5 | difficulties regarding preparation, if any | 1. Yes | 2. No | 3. Not applicable | 4. Do not know |
| 4.2 | **About post-operative care** | | | | |
| 4.2.1 | care of stitches | 1. Yes | 2. No | 3. Not applicable | 4. Do not know |
| 4.2.2 | diet/medicines | 1. Yes | 2. No | 3. Not applicable | 4. Do not know |
| 4.2.3 | work/rest | 1. Yes | 2. No | 3. Not applicable | 4. Do not know |
| 4.2.4 | sexual relations/intercourse | 1. Yes | 2. No | 3. Not applicable | 4. Do not know |

TOOL

| | | | | | |
|---|---|---|---|---|---|
| 4.2.5 | menstrual cycle | 1. Yes | 2. No | 3. Not applicable | 4. Do not know |
| 4.2.6 | follow-up visit | 1. Yes | 2. No | 3. Not applicable | 4. Do not know |
| **4.3** | **About men's responsibility towards their partners** | | | | |
| 4.3.1 | allowing the woman to rest/ensuring that she does not do heavy work | 1. Yes | 2. No | 3. Not applicable | 4. Do not know |
| 4.3.2 | diet/nutrition | 1. Yes | 2. No | 3. Not applicable | 4. Do not know |
| 4.3.3 | medicines | 1. Yes | 2. No | 3. Not applicable | 4. Do not know |
| 4.3.4 | sexual relations/intercourse | 1. Yes | 2. No | 3. Not applicable | 4. Do not know |
| 4.3.5 | follow-up visits | 1. Yes | 2. No | 3. Not applicable | 4. Do not know |
| **5** | **Encouraging clients to ask questions and share difficulties:** Did the counsellor | | | | |
| 5.1 | ask if the client had any queries or doubts? | 1. Yes | 2. No | 3. Not applicable | 4. Do not know |
| 5.2 | answer the questions raised? | 1. Yes | 2. No | 3. Not applicable | 4. Do not know |
| 5.3 | ask the client if she had any difficulties regarding post-operative care? | 1. Yes | 2. No | 3. Not applicable | 4. Do not know |
| 5.4 | (if the client had difficulties) discuss the problems and suggest ways of overcoming them? | 1. Yes | 2. No | 3. Not applicable | 4. Do not know |
| **6.** | **Reducing fear and giving reassurance:** | | | | |
| 6.1 | did the counsellor reassure the client if she was worried or scared about the surgery? | 1. Yes | 2. No | 3. Not applicable | 4. Do not know |
| 7 | **Confirming whether the information given is understood by the client before she leaves the room:** Did the counsellor | | | | |
| 7.1 | ask the client if she had any doubts or queries regarding information given? | 1. Yes | 2. No | 3. Not applicable | 4. Do not know |
| 7.2 | asked the client to repeat the key points of the information provided? | 1. Yes | 2. No | 3. Not applicable | 4. Do not know |
| 7.3 | ask the client to repeat the date fixed for the follow-up visit? | 1. Yes | 2. No | 3. Not applicable | 4. Do not know |

T-10.5

# Orientation Package to Sensitise Resident Medical Officers to Importance of Counselling

*(Suggested outline)*

## BACKGROUND

As a part of their academic requirements, students pursuing a postgraduate degree or diploma in obstetrics and gynaecology from municipal medical colleges are posted at peripheral hospitals as Resident Medical Officers on a six months' rotation. These RMOs play a key role in improving the quality of services provided through the outpatient clinics at peripheral hospitals as well as ensuring the smooth functioning of the counselling centre established within the outpatient clinic. It was observed that the content and quality of orientation package contributed to the RMOs' acceptance of the system at the outpatient clinics.

This guideline for orientation was developed to assist the honorary doctors in familiarising newly posted RMOs to the process that resulted in the present system with the counselling centre, as well as the functioning of the counselling centre and their role in the outpatient clinic.

### 1. Is this outpatient clinic different? Why? How?

***Expected Answers***

- IEC material displayed
- Roles of providers displayed
- Cleanliness
- Counselling centre

### 2. How did it happen?

(a) Observation study: In 1999–2000 a study was conducted to document client–provider communication at the gynaecology outpatient clinic of a secondary hospital. Fifty instances of client–provider communication were observed and documented to identify issues affecting quality of care.

The findings of the study were

- Disrespectful behaviour — during consultation and PV
- Unmet information needs
- Lack of privacy

- Stress among providers
- Men excluded from consultation process

(b) Feedback was given to the providers: providers stated that communication with clients is affected because of following factors:

- Providers not aware about the quality of their communication with patients
- Individual traits
- Layout
- Lack of coordination among team members
- Other administrative issues like inadequate number of doctors and nurses resulting in a large number of clients per provider
- Difficulty in communication with illiterate patients — language and cultural barriers

(c) Suggestions for improvement: Following the discussion on factors affecting client–provider communication, the clinicians, nurses and attendants at the gynaecology outpatient clinic were asked to suggest ways to bring about improvement in the same. Key suggestions were:

- Feedback to providers about their communication style should continue (both positive and negative)
- Patient flow management
- Resources, e.g., curtains, seating arrangement, etc.
- External counsellors to assist
- Need to establish dialogue with administration to solve problems
- Coordination and communication between providers should be improved

(d) Interventions by WCHP: Interventions were planned on the basis of findings of the observation studies, factors identified by providers and the probable solutions suggested by them for improvement in client–provider communication. These interventions included

- Changing the layout of the gynaecology outpatient clinic at V. N. Desai Hospital
- Establishing a counselling centre at the gynaecology outpatient clinic
- Male counsellors
- Clarifying and displaying the roles of each team member across all cadres
- Holding monthly/bimonthly meetings for problem solving

- Feedback continued to every batch of Resident Medical Officers (RMOs)
- Suggestion box for clients and staff
- IEC material
- Health education sessions for ANC patients
- Orientating the team (Resident Medical Officers (RMOs), nurses and attendants to newer systems introduced in the outpatient clinic, thereby ensuring ownership
- Introducing a token system to streamline the flow of clients

3. **All these interventions were based on the principles of 'Quality of Care' (QOC). So what is QOC? What is 'quality' service?**

Quality Service

- Giving more than client's expectations
- Subjective - can mean different things to different people

| ***Different points of view on 'quality'*** | | |
|---|---|---|
| Clients' perspective<br>Getting what the patient/client expects from health services | Health care providers' perspective<br>Whether services meet the needs as defined by professional standards | Administrators' perspective<br>Most efficient and productive use of services |

4. **Elements of Quality of Care :** Nine elements of Quality Framework proposed by Judith Bruce

| Generic Elements | Service Specific Elements |
|---|---|
| • Service environment<br>• Client–provider interaction<br>• Informed choice<br>• Information onservices<br>• Women's participation in management | • Access to services<br>• Equipment and supplies<br>• Professional standards and technical competence<br>• Continuity of care |

5. **Evaluation of Intervention**

In July 2003 (18 months after the counselling centre started functioning), the counselling centre was evaluated by an external evaluator. Twelve clients and 15 health care providers who were posted at the gynaecology outpatient clinic at the time of evaluation were interviewed. Interviews were also conducted with six ANMs and four MPWs who had earlier been posted as counsellors at the counselling centre. Four women who had sought the services of the gynaecology outpatient clinic but had not been referred to the counselling centre were also interviewed.

The objectives of evaluating the counselling centre were

- To assess client satisfaction with the counselling services provided at the centre.

- To explore providers' perspective on counselling services.

The findings of the evaluation were:

- Except for one RMO, all doctors found the counselling centre very useful because it reduced their workload.
- Patients were better prepared for surgical procedures and better informed about hospital procedures because of the guidance they received at the counselling centre.
- Clients were satisfied with the services provided by the centre.
- Feedback from Suggestion Box in the outpatient clinic reflects on quality of services provided through this clinic and the counselling centre. This could be a means of regular monitoring

### 6. Expectations from Resident Medical Officers (RMOs)

- Understand your role and the roles of other team members.
- Work as a team with the counsellors.
- Be conscious of the quality of care provided.

Specific activities

- Self-administrated checklist for communication (see T-8.2).
- Referrals to counselling centre.
- Observation and feedback to counsellor.
- Provide technical information to counsellors.
- Documentation and discussion of cases if there is a difference of opinion between counsellor and doctor.

### 7. Principles of counselling

**Definition:** Exchange of information as a means of clarifying and resolving problems, enabling the client to make decisions for planned action.

| Components of Counselling | |
|---|---|
| • Establishing rapport<br>• Listening and questioning<br>• Discussion | • Obtaining information<br>• Giving information<br>• Decision-making |
| **Errors in Counselling** | |
| • Directing<br>• Moralising, preaching<br>• Denying client's feelings<br>• Breaking confidentiality | • Labelling<br>• Giving false reassurances<br>• Encouraging dependence<br>• Interrogating |
| **Counselling Skills** | |
| **Macroskills** | |
| • Clarifying<br>• Empathising<br>• Summarising | • Asking open-ended questions<br>• Giving reassurance<br>• Recapitulating |
| **Microskills** | |
| • Paraphrasing of content<br>• Appropriate use of silence<br>• Confrontation | • Reflection of feeling<br>• Focusing |

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Fact Sheet 11

# INFORMATION, EDUCATION AND COMMUNICATION

## Rationale

Group meetings held in the community revealed that people's perceptions and information needs are different from those assumed by health care providers. Communities in Mumbai comprise a mix of people with various linguistic, religious and cultural backgrounds, and their information needs and choice of media for seeking information are determined by their socio–cultural backgrounds and gender.

People have a right to obtain information about potential health hazards and the Public Health Department of MCGM responds to this right by developing and disseminating information, education and communication materials on various health issues. In order to generate awareness and bring about positive change in the health behaviour of people, IEC material should be based on the information needs of the people, taking into account their media preferences. IEC material that meets people's information needs and creates awareness is a valuable tool for generating needs-based health care services.

A review of existing IEC material such as posters, pamphlets and booklets produced by the state government and by the IEC department of MCGM revealed that it was not sufficiently gender sensitive or sensitive enough to the literacy levels and socio-cultural backgrounds of the its target audiences. The material was found to be useful in training health workers to convey health messages but needed to be explained when used in the community with groups whose literacy skills were limited. The tool used to review the IEC material is presented in T-11.1. Close interaction with MCGM's IEC department revealed that due to various constraints the material was not produced in a participatory manner.

As a part of its effort to improve the quality of reproductive health care available at health posts and dispensaries, the project undertook the task of introducing the concept of gender-sensitive, client-friendly and participatory IEC material development in the MCGM. Based on this, the project produced IEC material on selected RH conditions.

## Activities

- An IEC Core Committee was formed comprising the staff of MCGM's IEC Cell to facilitate dialoguing between primary level health workers and those staff members of the IEC Cell who produced the material.
- Three training workshops were conducted for Core Committee members on the philosophy and principles of participatory material development and basic communication skills.
- Formative research was conducted to review existing materials and investigate the information needs and media preferences of women and men living in slum areas.
- A workshop was organised to demonstrate the process of developing IEC material in a participatory way by involving women from the community along with members of the IEC department and health care providers from health posts and dispensaries. This workshop illustrated how women's perspective and their information needs can be incorporated into the process of developing IEC material.
- Leaflets providing information on Reproductive Tract Infections and abortion, and a flannel graph for information on antenatal care were developed. The process of developing the leaflets is presented in T-11.2.
- Health education sessions were conducted regularly for women attending the antenatal care clinic at the secondary hospital.

## Achievements

- System for dialogue between primary level workers and IEC department staff established through the IEC Core Committee; health workers expressed satisfaction with the initiative in the midterm evaluation.
- IEC department staff became aware that the intended message was not understood by everyone uniformly. This resulted in an increased openness to suggestions and awareness of the importance of pre-testing.
- Primary health care workers enjoyed conducting and participating in group meetings with the community to find determine the information needs of men and women.
- Three NGOs participated in the workshop organised by the IEC department to prepare material on RTI. NGO representativens also conducted Focus Group Discussions along with health post staff.

- Training sessions on conducting health education sessions using interactive IEC material were included in the Integrated Skills Development Training of the RCH programme for all cadres.

## Constraints

- Most of the material produced by MCGM is not developed on the basis of formative research (though some observations in the community are used), nor is it pre-tested. Therefore this material may not meet the information needs of the urban poor in Mumbai. However, incorporating community perspectives by using a participatory methodology is time consuming and this is not always possible due to time constraints and the preoccupation of staff in other activities.
- There is need to use qualitative research methods like Focus Group Discussions to incorporate the community's perceptions before planning IEC strategies. MCGM needs to enhance staff's skills to conduct formative research.
- Ad hoc demands for IEC materials do not always allow for the use of participatory methods to produce the materials.
- Various administrative problems resulted in disintegration of IEC Core Committee, thus reducing the chances for institutionalising the lessons learned by the project. However, interested health care providers did contribute to the process of developing the material in their individual capacity.

## Recommendations

*Regarding IEC material*

- Since a sizeable proportion of the population in Mumbai is neo-literate, IEC strategies should not rely primarily on the written text for communicating messages. Efforts must be made to develop a variety of approaches including street plays and interactive material.
- IEC activities should be planned to enable discussion with the community following the demonstration of the IEC material.
- Health care providers as well as the department staff should be trained in the participatory use of IEC materials.

*Regarding the process of material development*

- The process of material development should involve primary health care workers.

- People's perceptions on a particular issue elicited through group discussions with CHVs and men and women from the community should be given due importance while developing IEC material.
- IEC material should be used in an interactive manner to allow men and women to express their concerns and doubts.
- All IEC material needs to be pre-tested before large-scale production.
- The steps involved in the process of participatory development of material need to be documented and followed for all material developed by the IEC Cell.

*Skill development*

- Provide staff with the option to attend workshops to enhance their skills in participatory processes.
- Assess the communication skills of grassroots level workers and train them to make and use health education and IEC material through a two-way process.
- Monitor the communication style of providers in interpersonal (one-to-one) and group situations. There is a need to develop a monitoring system to assess the quality of their contacts with the community.

***Expected Role of Programme Officers (Deputy Executive Health Officers or Assistant Health Officers in charge of various National Programmes implemented through the Public Health Department of the Municipal Corporation of Greater Mumbai)***

- Programme officers should budget for sufficient time, funds and human resources within MCGM for developing IEC materials using the participatory process.

***Expected Role of Assistant Health Officer in Charge of IEC CELL (AHO - IEC)***

- Ensure that a participatory process is used to develop and produce IEC material. Community Development Officers should play active role in this process.
- Orient, guide and encourage the IEC Cell staff to use the participatory process.
- Coordinate with other experts for introducing new concepts and methodologies in IEC.
- Arrange ongoing workshops for upgrading/refreshing the skills of health

workers, IEC Cell staff and CDOs for producing user/client-friendly IEC material.

***Expected Role of Community Development Officers (CDOs)***

- Supervise and monitor the use of participatory methods in the development and use of IEC material produced by the IEC Cell as well as by health posts and dispensaries.
- Guide grassroots health care providers in the use of interactive methods for IEC.
- Periodically organise and conduct ward-level training programmes for grassroots staff for producing and using effective IEC material.
- Ensure adequate supply of IEC material at health post and dispensary level.
- Plan and conduct focus group discussions or other activities to get feedback on IEC materials as well as dissemination techniques used by health care providers.
- CDOs should accept overall responsibility for IEC at the ward level.

**List of Tools**

T-11.1 : Checklist for Review of Printed IEC Material

T-11.2 : Protocol for Development of Gender Sensitive, Interactive IEC Material

T-11.1

## Checklist for Review of Printed IEC Material

The quality of printed IEC material depends on n five components: (*a*) visuals, *(b)* language, (*c*) type and size of font used,(*d*) content, and (*e*) user-friendliness. The following checklist used these points to assess the quality of printed IEC material. The reviewer is required to assign a score on the scale of one to five for each of the criteria listed in the checklist. Scores are then added to obtain an overall rating for the material. A higher score indicates better quality or greater acceptability of the material. While using this checklist, it must be remembered that this is a subjective tool and is more effective if used by individuals with some background in the development and use of printed IEC material.

**Title:** _____ **Type:** _____ **Produced by :** _____

| | Criterial for evaluation | Score |
|---|---|---|
| | | Very Poor _____ Very Good |
| | ***Visuals*** | |
| 1 | Key message clear | 1_____3_____5 |
| 2 | Accuracy of content | 1_____3_____5 |
| 3 | Enough visuals | 1_____3_____5 |
| 4 | Literacy-sensitive visuals | 1_____3_____5 |
| 5 | Appropriately placed | 1_____3_____5 |
| 6 | Culture sensitive | 1_____3_____5 |
| 7 | Gender sensitive | 1_____3_____5 |
| 8 | Age sensitive | 1_____3_____5 |
| 9 | Appeal | 1_____3_____5 |
| | ***Language*** | |
| 10 | Simple language | 1_____3_____5 |
| 11 | Technical language | 1_____3_____5 |
| 12 | Language sensitive | 1_____3_____5 |
| 13 | Culture sensitive | 1_____3_____5 |
| | ***Font*** | |
| 14 | Font size | 1_____3_____5 |
| 15 | Use of style (emphasis) | 1_____3_____5 |
| | ***Content*** | |
| 16 | Quality of matter | 1_____3_____5 |
| | ***Convenience to user*** | |
| 17 | Handy to use | 1_____3_____5 |
| 18 | Appropriate thickness | 1_____3_____5 |
| 19 | User friendly | 1_____3_____5 |
| 20 | General appeal | 1_____3_____5 |

TOOL

T-11. 2

# Protocol for Developing Gender-Sensitive, Interactive IEC Material

**Steps involved in the development of gender-sensitive, interactive IEC material**

Explore/determine the information needs of men and women of the community

↓

Identify content required to meet expressed information needs

↓

Develop illustrations pertaining to the information, making sure that they do not reinforce gender stereotypes and unequal gender relations

↓

Get feedback from men and women health workers from all cadres including doctors

↓

Pre-test in the community

↓

Modify based on feedback received

↓

Check with doctor for technical accuracy before finalising content

↓

Printing

↓

Training to health care providers in use of IEC material

Fact Sheet 12

# REFERRAL SYSTEM

## Rationale

Focus group discussions and exit interviews conducted in the first phase of the project showed that the waiting time and cost of services to the users were higher for clients visiting secondary centres than the primary level health care facilities. Exit interviews revealed that the average waiting time per outpatient clinic contact was 2 hours and 30 minutes at the secondary hospital, 45 minutes at the dispensary and 21 minutes at the health post.

The lack of a systematic referral system was among the other factors identified by providers in the first Quality Assurance Workshop (February 1997) that adversely affect quality of care. The factors for which the providers felt that it was possible to bring about some changes at the facility level were:(*a*) communication between patients and providers, (*b*) referral, and (*c*) drug availability to patients. Following the workshop an intervention study was launched 'to determine changes that were possible in the referral system' changes in the referral system.

## Activities

- The inadequacy of the referral system as a factor affecting quality of health care was discussed at the first Quality Assurance Workshop.
- A small group of health care providers, middle level administrators and representatives of WCHP worked together to develop a pilot referral system for users of gynaecological and obstetric services through health posts and dispensaries.
- Following a discussion at the second Quality Assurance Workshop (January 1998) and revision of the tool after the workshop, the amended referral system was piloted in two project wards in three phases over a period of 18 months (see Annex 12.1). The referral slip used during the pilot phases is presented in T-12.1.
- Feedback was obtained from health care providers who reviewed the pilot referral system.
- Experiences of using the referral slip were shared with three municipal tertiary hospitals attached to medical colleges. Two of the hospitals

expressed interest, one of which adopted the referral system for implementation in its catchment area.

- WCHP collaborated with SNEHA — a non-governmental organisation working to reduce perinatal mortality in Mumbai — to develop a detailed referral protocol (this draft protocol is available with WCHP)
- Members of the Working and Support Groups reviewed the referral system established in Thane district under the World Bank-funded Maharashtra Health Systems Development Project.
- WCHP's experience of developing and implementing the referral system was shared in the ISDT of RCH.

**The process followed in referral system**

- Client approaches health post or dispensary, is examined by the medical officer and is found in need for 'referral'.
- Details are filled on the referral slip and client is referred to the referral centre.
- The referring unit retains the first part of the slip.
- The second, third and fourth parts of the slip are carried by the patient to the referral centre.
- Patient gets priority at the senior citizens' registration window by showing the referral slip.
- The registration assistant retains the second part of the slip.
- Patient using the referral slip gets priority at par with MCGM employees and senior citizens at the outpatient clinic.
- The examining doctor in the outpatient clinic fills up the third and fourth part of the referral slip after examining the client.
- The referral centre retains the third part of the slip.
- The patient reports to the referring unit with the fourth part of the slip, thus providing it with feedback.

## Achievements

- The project demonstrated the feasibility and usefulness of introducing a referral system in the MCGM.
- The project documented the prerequisites and constraints for institutionalising the referral system and developed a draft referral protocol for gynaecology and obstetrics in collaboration with another NGO.
- The project's work in this area could serve as a guideline for for developing referral protocols and implementing the referral system in MCGM.

## Constraints

- Lack of detailed guidelines for referral led to unnecessary referrals (e.g., referral for medicine only, etc.) and resulted in decreased enthusiasm from medical officers at the referral centre.
- Not involving all staff from the referral centres in the development of the referral procedures led to insufficient clarity, which resulted in the referred clients not receiving 'priority' at the outpatient clinics.
- There was lack of clarity about what is meant by 'priority' — doctors from referring units were disappointed that the clients had to wait in a queue; as a result, the number of clients referred also declined steadily.
- Referral from secondary to primary level could not be initiated.
- Insufficient dialogue between the primary and secondary level facilities.
- While referring clients, due consideration was not given to the distance of referral centre from the client's residence. This de-motivated clients from using the referral services.

## Lessons Learnt

- Assigning priority on par with MCGM employees or senior citizens ensures increased compliance of clients with the referral system.
- A comprehensive referral system with protocols or guidelines for uniform implementation is essential for its success.
- Along with technical protocols, administrative protocols or guidelines are essential for ensuring quality of referral services.

## Recommendations

- Technical and administrative protocols or guidelines should be developed for ensuring effective referral services.
- Primary level facilities need to be strengthened in terms of technical skills and knowledge as well as in terms of material resources in keeping with the referral protocols.
- All staff concerned with referrals, whether from referring units or referral centres, should be sensitised to the referral procedures, especially to the concept of priority.
- Referred clients should be assured priority (at par with the MCGM staff and senior citizens).
- A system needs to be developed for feedback to referring units.
- Referral from secondary to primary level for chronic conditions should be encouraged.

- Activities for capacity building such as CMEs for all cadres of health care providers need to be incorporated in the referral programme.
- Mechanisms should be developed to monitor quality (effectiveness) of the referral system.

***Expected Role of Deputy Executive Health Officers (DEHOs) And Assistant Health Officers (AHOs)***

- Develop administrative protocols for effective implementation of the referral system.
- Ensure support from teaching hospitals for monitoring and strengthening the technical aspects of care at health posts, dispensaries and secondary general hospitals.
- Seek the assistance of senior administrators to meet the material requirements for strengthening primary level services.
- AHOs and DEHOs could help sort out problems between the referring unit and referral centres through supportive supervision.
- Arrange quarterly coordination meetings with referring units and referral centres.
- Address problems relating to the referral system during staff grievance meetings.
- Information on referral should be incorporated in the routine MIS of the MCGM.

***Expectations From Medical Officers of Health (MOsH)***

- Implementation of systematic referral system should be considered as part of the agenda for supervisory visits. Relevant issues should be discussed in monthly ward-level and grievance meetings.
- MOsH should take the initiative in establishing a dialogue between the secondary and primary facilities by organising regular meetings with clinicians from referring units and referral centres.
- MOsH should review data regarding referrals and address the issues emerging from it.

**List of Annexes**

Annex 12.1: Findings of Pilot Phase of Referral Study

**List of Tools**

T-12.1 : Referral Slip Used for Test Intervention

# Annex 12.1

## Findings of Pilot Phase of Referral Study

**Table 1: Results from the pilot implementation of referral system in three phases**

| | Duration | No. of facilities participating in exercise | Number of clients referred | Number of clients registered at the referral centre |
|---|---|---|---|---|
| Phase I | 1 month | 14 — one ward | 178 | 33% |
| Phase II | 1 month | 14 — one ward | 132 | 65% |
| Phase III | 12 months | 22 — both wards | 769 | 45% |

**Table 2: Proportion of clients availing referral services at the designated referral centre**

**(Phase I: Mid-February to mid-March 1998)**

| | Health Posts | Dispensaries | Total |
|---|---|---|---|
| Referred to designated referral centre (n) | 85 | 93 | 178 |
| Availed services from designated referral centres | 37 (43%) | 22 (24%) | 59 (33%) |

**Table 3: Reasons for not availing services at the referral centre**

**(Phase I: Mid-February to mid-March 1998)**

| | Health Posts | Dispensarie | Total |
|---|---|---|---|
| Referred to designated referral centre (n) | 85 | 93 | 178 |
| Availed services from designated referral centres | 11 (13%) | 4 ( 4%) | 15 ( 8%) |
| Availed of services at private hospitals[1] | 7 ( 8%) | 14 (15%) | 21 (12%) |
| Did not go anywhere | 13 (15%) | 28 (30%) | 41 (23%) |
| Lost to follow-up[2] | 17 (20%) | 25 (27%) | 42 (24%) |

**Table 4: Proportion of clients availing referral services at the designated referral centre**

**(Phase II: Mid-March to mid-April 1998)**

| | Health Posts | Dispensaries | Total |
|---|---|---|---|
| Referred to designated referral centre (n) | 25 | 107 | 132 |
| Availed services from designated referral centres | 14 (56%) | 73 (68%) | 87 (66%) |

**Table 5: Reasons for not availing services at the referral centre**

**(Phase II: Mid-March to mid-April 1998)**

| | Health Posts | Dispensaries | Total |
|---|---|---|---|
| Referred to designated referral centre (n) | 25 | 107 | 132 |
| Availed services from designated referral centres | 1 (4%) | — | 1 (1%) |
| Availed of services at private hospitals[1] | 4 (16%) | 9 (8%) | 13 (10%) |
| Did not go anywhere | 1 (4%) | 11 (10%) | 12 (9%) |
| Lost to follow-up[2] | 5 (20%) | 14 (13%) | 19 (14%) |

**Note:** [1] Proportion of clients should be considered while calculating rate of successful referrals.
[2] This category refers to clients who could not be traced either because the house was locked or because the address was found to be incorrect.

T-12.1

# Referral Slip Used for Test Intervention

**BRIHANMUMBAI MUNICIPAL CORPORATION**

**NAME OF REFERRAL UNIT:** **DEPARTMENT:**

**OPD Timings :**

**Outpatient Clinic No.:** **Outpatient Clinic Day:** **Outpatient Clinic Timings : Client's Postal**

**Address :**

**Part A**: To be filled in by MO /FTMO /PHN /ANM /MPW and retained by the **REFERRING UNIT**

To, **Ref.No.____/_____**

The MO, _____,

This is to refer ..... aged..... with presumptive diagnosis of ....., for clinical examination, investigations and advice. Please do the needful and send the client back along with following note filled in by you.

**Date** : .....

Rubber Stamp

_____

Signature of MO /FTMO /PHN /ANM /MPW

**BRIHANMUMBAI MUNICIPAL CORPORATION**

**NAME OF REFERRAL UNIT:** **DEPARTMENT:**

**OPD Timings :**

**Outpatient Clinic No.:** **Outpatient Clinic Day:** **Outpatient Clinic Timings :**

**Client's Postal Address :**

**Part B**: To be filled in by MO /FTMO /PHN /ANM /MPW and retained by the **REFERRAL UNIT**

To, **Ref.No.____/_____**

The MO , _____,

This is to refer ..... aged..... with presumptive diagnosis of ....., for clinical examination, investigations and advice. Please do the needful and send the client back along with following note filled in by you.

**Date** : .....

Rubber Stamp

_____

Signature of MO /FTMO /PHN /ANM /MPW

**BRIHANMUMBAI MUNICIPAL CORPORATION**

**REFERRAL CENTRE:** **DEPARTMENT:** **Outpatient Clinic No.:**

**Name of the client:**

**PART C** To be filled by MO at referral centre and to be retained at **REFERRAL CENTRE**

To, **Ref.No.____/_____**

The MO / FTMO

Patient .....referred by your centre was examined clinically and investigated at this hospital.

**Findings**:

**Advice** :

**Advised follow up on**:

Date : .....

_____

Signature and Rubber Stamp of MO

TOOL

**BRIHANMUMBAI MUNICIPAL CORPORATION**

**REFERRAL CENTRE:** **DEPARTMENT:** **Outpatient Clinic No.:**

**Name of the client:**

**PART C** To be filled by MO at referral centre and to be retained at **REFERRAL CENTRE**

To,
The MO / FTMO

Ref.No. _____/_____

Patient .....referred by your centre was examined clinically and investigated at this hospital.

**Findings**:

**Advice**

**Advised follow up on**:

Date: .....

_____

Signature and Rubber Stamp of MO

Fact Sheet 13

# MANAGEMENT INFORMATION SYSTEM

## Rationale

In the first Quality Assurance workshop, the large amount of paper work (numerous registers that health workers are required to maintain) was identified as one of the factors that limit time spent by health care providers with the clients, thus compromisjng the quality of care delivered. The need to revise the existing MIS to reduce paperwork and eliminate duplication of reports was expressed by a cross-section of health care providers and middle level administrators. A review of the MIS formats found them to be lacking in gender sensitive indicators. Shifting focus from quantity to quality, the project undertook a review of the MIS formats used by MCGM and proposed alternatives for more meaningful MIS.

## Activities

- Review of existing MIS showed repetition of information in various forms.
- Interviews were conducted with health care providers to get their perspective on existing MIS.
- A literature review on quality and gender sensitive indicators was carried out.
- A small subcommittee was established to study and propose the revisions in MIS.

## Achievements

- WCHP developed a set of quality criteria with standards and quality indicators for each service being provided (and to be provided) by dispensaries and health posts. Details of how these could be made operational were also worked out (T-13.1).
- The project developed a Family Health Card as an alternative to the baseline register (T-13.2)
- The project also designed a list of selected indicators for general and reproductive health services (T-13.1)
- Various MIS formats were compiled to develop a format that avoided duplication.

- A subcommittee of health care providers from all cadres recommended steps for reducing the burden of MIS on health post staff.

## Constraints

- The formats developed by the project have not been field-tested or discussed with the concerned officers and/or health care providers.
- Efforts of the subcommittee could not be sustained.

## Recommendations

- Effective MIS can play a key role in ensuring the quality of health care services by helping health care providers and administrators to identify areas that require strengthening. Streamlining the MIS should be given priority for effective implementation of RCH programme.
- Existing indicators need to be reviewed from a gender perspective and gender sensitive indicators should be included in the MIS for MCGM.

**Suggestions for Streamlining of MIS — Group Work at Convergence Workshop ( 9-10 September 2001)**

- MIS formats should be revised to eliminate repetition.
- Modifications suggested for reporting formats for FW & MCH/ RCH.
- Arrangements should be made to allow submission of all reports at one place.
- Subject registers should be maintained. These registers should allow for recording by all ANMs and MPWs. ANMs and MPWs should share the responsibility of maintaining the registers.
- MCGM should ask for quarterly reports instead of bimonthly ones. Reports should cover changes from the time the last report was sent.
- Team spirit is important and should be encouraged.
- A format for the complaint letter was developed for informing departments other than the health department about issues that have an implication for health services. It was suggested that this complaint letter be submitted to complaint officer of each ward.
- A Family Health Card should be developed and used instead of follow-up registers.

***Expected Role of Deputy Executive Health Officer in Charge of Cells (DEHO Cells) (AHO MIS) and Assistant Health Officer in Charge of MIS***

- Guide the process of reviewing and revising the MIS formats.
- Follow up efforts for streamlining MIS.
- Ensure gender-sensitive indicators in the MIS.

**List of Tools**

T-13.1 : Select Indicators for General and Reproductive Health Services

T-13.2 : Family Health Card

T-13.1

# Select Indicators for Quality of General and Reproductive Health Services

**Facility's Name** _____ **Month** _____

_____

**Related to general outpatient clinic**

1. No. of clients : (Old) Male ____ Female ____ (New) Male ____ Female ____ Total ____
2. No. of clients satisfied with privacy : Male ____ Female ____ Total ____
3. No. of clients physically examined : Male ____ Female ___ Total ____
4. Drugs not available (name)

**Source of data**: Outpatient Clinic Records for 1 and 4; Exit Interviews for 2 and 3.

**Related to contraception services**

5. No. of couples for FP adequately informed about methods and their implications
6. No. of couples counselled about FP
7. No. of FP acceptors with complications, method-wise
8. No. of women becoming pregnant while using FP methods

**Source of data**: Exit Interviews for 5 and 6; Records for 7 and 8.

**Related to child immunisation**

9. No. of children < 12 months Male ____ Female ____ Total ____
10. No. of children < 12 months fully immunised Male ____ Female ____ Total ____
11. Potency test of vaccines done (with date)
12. Cold chain regularly maintained
13. No. of children < 12 months with post-immunisation complications

**Source of data**: Outpatient Clinic Records for 9 and 13.

**Related to Well Women Clinic**

14. No. attended Well Women Clinic
15. No. of earlier users of WWC brought new clients
16. No. of women found the providers sensitive to their problems
17. No. of women reported use of protocols for diagnosis
18. No. of PAP smears taken
19. No. of women screened for breast cancer _____ cervical cancer _____
20. No. of women taught self-examination for breast cancer
21. Total MTPs _____ No. of MTPs < 12 weeks _____ > 12 weeks _____

22. No. of MTPs followed up
23. No. of unwed mothers with MTPs

**Source of data**: Exit Interviews for 15, 16, 17 and 21; Records for 18 to 23.

## Related to Well Baby Clinic

24. Total no. of new mothers
25. No. of new mothers informed
26. No. of newborns checked up
27. No. of babies born < 40 weeks
28. No. of babies born < 2,500 gms
29. No. of babies initiated to breast feeding within 6 hours
30. No. of children with episode of ARI _____ Acute Diarrhoea _____
31. No. of children dewormed
32. No. of children given PANA-C

**Source of data**: Exit Interviews for 26 and 30; Records for others.

## Related to outreach services

33. No. of patients detected and referred to health posts
34. No. of referrals followed up at their residence
35. No. of adolescent girls counselled
36. No. of groups formed
37. Details of group activities conducted (topics, attendance, etc.)

    Topic : _____ _____ _____ _____

    Attendance : M_____ F _____ M_____ F_____ M_____ F_____ M _____ F_____
38. Details of IEC activities carried out

    1.

    2.

    3.

**Source of data**: HP Records for 33 to 38.

## Related to gender-specific health services

39. No. of women provided treatment for STI, partners treated, counselling and information given to the couple
40. No. of women provided treatment for menstrual problems
41. No. of women provided treatment for infertility
42. No. of women provided antenatal services

**Source of data**: HP Records for 39 to 42.

T-13. 2

# FAMILY HEALTH CARD

**Family Card Part-1: RECORD OF HOUSEHOLD DETAILS, MARRIAGES, BIRTHS & DEATHS**

**Part II: ANC/PNC SERVICES. Part III: CHILD IMMUNISATION. Part IV: FAMILY WELFARE SERVICES Part V: OTHER HEALTH SERVICES**

Ward _____ HP _____ locality _____ CHV of the area _____ This card filled in by _____ on _____

Sl.No._____ HH No. _____ Head of HH _____ Religion/Caste_____ HH main occup._____ HH members Total _____M _____F _____Earning members _____Total monthly income _____

Whether BPL _____ if yes, benefits taken _____ Type of house Walls _____ Roof

Toilet: In-HOUSE/MCGM/MHADA/COMMON/NO TOILET

Electricity: Own meter: Site owner: Proof of residence: Ration Card: Source of water:

| Sl No | Names of the household members (beginning with the Head) | Relation with the Head | Sex | Age | Ed | Main Occ | MS | Age at Mar | No. of live Births M/F | | If currently preg. write **detection date** and gestational **week** and fill in the ANC section | | If adopted FP, write method & date since started & fill in FP section | | Immn.status of U-5s Fill in the Sec.III for next doses | | | | | If any health problem, write here and fill in Sec.V | Remark |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | M | F | Detection date | Gest week | Method | Date | BCG | OPV | DPT | MSL | Vit A | | |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 |
| 1 | | | | | | | | | | | | | | | | | | | | | |
| 2 | | | | | | | | | | | | | | | | | | | | | |

Write the date of visit in the month column and the action taken or event found in the column next to month. Write 'L' if the house found locked

| Year | Jan | | Feb | | Mar | | Apr | | May | | Jun | | Jul | | Aug | | Sep | | Oct | | Nov | | Dec |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2000 | | | | | | | | | | | | | | | | | | | | | | | |
| 2001 | | | | | | | | | | | | | | | | | | | | | | | |
| 2002 | | | | | | | | | | | | | | | | | | | | | | | |
| 2003 | | | | | | | | | | | | | | | | | | | | | | | |

FACT SHEET 13 MANAGEMENT INFORMATION SYSTEM

**Part II: Related to Pregnancy, Delivery, Post-Natal and Neo-Natal aspects**
(Note # The date of visit column could be used for one pregnant woman whenever she is visited or only one line at the time of detection/registration of the pregnancy and one month after the delivery)

| Date of visit | Name | Date of detection | Gestational week | EDD | Any health problems | Whether anaemic | High risk factor | Ante Natal Services | | | | | Outcome with place and date LB/SB/AB with sex | Place of delivery (Hosp./ Home) | Complications at Del. and action taken | Health status of new born | Birth wt. (gm) | If death, age, date and cause | Remarks |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | TT | FS | BP | WT | ED | | | | | | | |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 |
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**Part III: Related to Child Immunisation and Prophylatics** (date for each kind and dose of immunisation is to be written under the respective column)

| Child's Name | Sex | Age in month | BCG | Polio | | | | | | | DPT | | | | | MSL | VitA | | | | ORS | Complication if any, and action taken by health worker | Remarks |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | 0 | 1 | 2 | 3 | B-1 | B-2 | PP | 1 | 2 | 3 | B-1 | B-2 | | 1 | 2 | 3 | 4 | | | |
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**Part IV: Contraceptive (Family Planning) Services**

| Name | Sex | Age | Age at Mar. | No.of living children | | If adopted a permanent FP method | | If using Cu-T | If using a spacing method, Write method's name : Enter date in the boxes when the method is supplied | Any complaints, difficulties and action taken by health worker | Remarks |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | M | F | Method | Year | Since when | Note: For condom, write number of pieces below the date | | |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 |
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**Part V : Information on illness and its treatment**

| Date | Name | Sex | Age | Illness | | Date of onset | Action taken by health worker | Source of Treatment | Duration of Treatment | Outcome of treatment | Remarks |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | Self-reported | Based on diagnosis | | | | | | |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 |
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**FINDINGS OF THE HOME VISITS AT A GLANCE**

| House Hold No. | Name of the Head | Month-wise date of visit, event took place and action taken should be entered in following column | | | | | | | | | | | | Remarks |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Date | Event/ Action | Date | Event/ Action | Date | Event/ Action | Date | Event/ Action | Date | Event/ Action | Date | Event/ Action | |
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# PART III

# ADVOCACY

## Introduction

The Women Centred Health Project had its roots in a research study that identified issues affecting the quality of services that were considered important by the women clients of the Public Health Department (PHD) of the Municipal Corporation of Greater Mumbai (MCGM). Along with highlighting the issues affecting quality of care provided by the municipal health care services, the PID study also emphasised that these issues could only be remedied by action from within the system and that health providers have a key role to play in this process.

WHCP explored and piloted strategies that would be feasible within the public health system. The outcomes of implementing tested interventions were presented in the year 2000, when the central government was developing a policy for the Urban Reproductive and Child Health Programme. This gave the project an opportunity to present the findings at the national level and thus contribute to the development of training modules for Integrated Skill Development Training for Urban RCH. Trusting the project's experience, NIHFW granted MCGM permission to modify the national training modules to suit specific needs of the metropolis.

This section presents the project's advocacy efforts to mainstream gender and quality aspects into public health systems.

Fact Sheet 14

# CONTRIBUTIONS TO INTEGRATED SKILL DEVELOPMENT TRAINING FOR RCH

## Rationale

WCHP's goal of expanding the range and improve the quality of reproductive health services fitted well with the comprehensive reproductive health package advocated by the national Reproductive and Child Health Programme. The training component of the national RCH Programme was introduced in Maharashtra in the year 2000, when WCHP was in its second phase of interventions. The project had gathered considerable experience in planning and organising participatory training programmes on issues related to reproductive and sexual health. By piloting interventions, the project was able to share lessons learned and the important issues involved in introducing comprehensive sexual and reproductive health care at the primary level. The Project Coordinator (who is an Assistant Health Officer [AHO] in MCGM's Public Health Department) was identified as a key trainer by the state RCH training centre, and was later appointed as the Training Coordinator for RCH training in Mumbai. In all, 22 officers from the PHD (administrators, paediatricians and gynaecologists) were trained as key trainers at the state RCH training centre.

The project saw Integrated Skill Develcpment Training (ISDT) for the National Programme on Reproductive and Child Health (RCH) as an opportunity for institutionalising the concept of gender-sensitive, client-centred, quality RH by reaching all health care providers of the Public Health Department.

## Activities

The contribution made by WCHP to the Integrated Skills Development Training (ISDT) can be broadly categorised as (*a*) capacity building of key trainers, (*b*) inputs for the development of a more urban-oriented curriculum, (*c*) advocacy for implementing the RCH Programme, and (*d*) other contributions.

### a) Capacity building of key trainers

- Following the training at the state training institute, the project organised a four-day workshop on participatory training methodology for key trainers.

During this workshop key trainers were introduced to the principles of participatory training methodology and the skills required for conducting such training. A two-day workshop as a follow-up of the first workshop ensured the application of participatory principles in designing the sessions.

- WCHP provided administrative and technical support to the key trainers for over a year.
- A few male clinician key trainers were invited to attend a workshop on Gender and Health that was organised by WCHP and conducted by an experienced team of male trainers. This workshop helped key trainers develop a gender perspective and understand the links between reproductive health issues and gender — a learning that they found helpful when conducting sessions on clinical topics.

**b) Inputs for development of a curriculum suitable to the urban situation**

- Training modules for each cadre were reviewed to identify gaps vis a vis the urban health scenario. While some sessions were modified to meet the needs of an urban health delivery system, some (see Box 1), such as the ones on perspective building, counselling, communication and quality of care were freshly incorporated in the training modules. Details of modifications to each module are presented in Annex 14.2. The project also proposed job descriptions for all cadres within the framework of the National Programme on Reproductive and Child Health (Annex 14.1), which were discussed in various workshops conducted by the project. A list of topics for which health care providers are required to provide information and counselling to clients is presented in T-14.2.

**Box 1**

**Points for reviewing ISDT modules**

- *Does the content meet training needs as per job responsibilities of each cadre of health care providers?*
- *Does the module contribute to the development of a perspective for women centred health care?*
- *Does the module have sessions on gender sensitivity and men's involvement? Are these well defined?*
- *Is a quality assurance component incorporated throughout the module?*
- *Is the content relevant to training in the urban health scenario?*
- *What are the other inputs/sessions required in the module?*
- *Are the social and clinical components linked to each other?*
- *Does the training empower the trainee to improve skills for working with people?*

**Topics included in ISDT module for RCH for all categories**

- *Perspective building on gender and women's health.*
- *Quality of care.*
- *Planning for health education.*
- *Group dynamics and facilitation skills.*
- *Infertility.*
- *Counselling.*
- *Geriatric health.*

**c) Advocacy efforts for the RCH programme**

- WCHP has been advocating the need for training CHVs for some time now. Towards this end, it presented the proposed training modules for CHVs at various fora at state and central levels.
- In various meetings at the national level, senior persons from WCHP presented the lessons learned in terms of the potential role of MPWs, communication and counselling relating to sexuality, woman-centred quality of care, provision of reproductive health services at the primary level and the importance of incorporating a rights' perspective, specifically the Charter on Patients' Rights and Responsibilities.

**d) Other contributions**

- Apart from the Project Coordinator, two members of the WCHP team conduct sessions as external resource persons on Counselling, Quality Assurance, Perspective Building in Women's Health, Gender and Health and Planning of Health Education for all the cadres in the RCH training.
- WCHP developed a six-day training programme for CHVs. An outline of the module is presented in T-14.1.

## Achievements

- The Project Coordinator presented the adaptations for urban RCH modules at the state and the central government level. These have been accepted by the NIHFW and are being implemented in Mumbai by MCGM. Other municipal corporations in Maharashtra are also using the adapted modules.
- All health care providers from MCGM's PHD and municipal teaching hospitals were trained in ISDT for RCH. The training programme was simultaneously conducted at three bureaus.
- The Project Coordinator, who is also the training coordinator for RCH, Mumbai, ensured uniformity in the quality of inputs to trainees from all bureaus by providing common reading materials and organising meetings between the coordinators of the three bureaus. The resource material was developed in joint meetings of all key trainers.

## Constraints

- The Reproductive Child Health (RCH) training modules do not include any module for Community Health Volunteers (CHVs). However, based on its experiences the project is convinced that building the skills of CHVs, who are the community's first point of contact with the health care delivery system, will result in improved quality of guidance to members of the

community. After receiving training on reproductive tract infections and menstrual disorders, the CHVs from the project wards showed improved efficiency in referring women suffering from these conditions to the gynaecology clinic at the health post. Exclusion of this important link from the training could adversely affect implementation of the RCH programme.

- Since MCGM has yet to receive permission and grants for implementing urban RCH, there will be a large time lag between the training programmes and implementation. This might result in dilution of knowledge gained through training and adversely affect its application in field.
- MCGM's PHD has been unable to initiate gynaecology clinics at primary level health care facilities due to budgetary constraints and severe shortage of health care personnel.

## Recommendations

- The selection of key trainers should not be based on administrative hierarchy within the system but on the interest, skills and experience of training, irrespective of cadre and designation.
- Participatory methods should be used in the clinicians' training module for RCH key trainers. Case studies, role plays and checklists should be part of the training methodology for clinical topics for all cadres.
- Along with hands-on training on clinical topics that is included in the present modules, hands-on training for building social skills and skills for counselling and group facilitation should be included in the modules.
- An intensive three-day workshop on Sexuality and Health and a three-day Counselling workshop should be part of the training module for key trainers as well as for all categories of health care providers.
- CHV training should form an integral part of the ISDT for RCH. This will help to strengthen the reach to the community as well generate more demand for services.

### List of Annexes

Annex 14.1 : Proposed Job Descriptions of All Cadres of Health Workers
Annex 14.2 : Modifications in the RCH Module Based on Job Descriptions for All Cadres

### List of Tools

T-14.1 : Proposed Session Plan for ISDT for Community Health Volunteers
T-14.2 : Topics for Counselling and Interpersonal Communication

Annex 14.1

# Proposed Job Responsibilities of Health Care Providers

## Services Provided Through Health Posts

*Services relating to:*

1. Antenatal care
2. Post-natal care
3. Family planning
4. Treatment of RTI/STI
5. Infertility
6. Child health — including immunisation
7. Safe abortion — referral, counselling and follow-up
8. Revised National Tuberculosis Control Programme
9. Disease surveillance
10. Health education for prevention and counselling for HIV/AIDS
11. Awareness for detection of leprosy under the National Leprosy Eradication Programme
12. Pulse Polio immunisation
13. Adolescent girls' health programme
14. Reproductive and Child health Programme
15. Other ad hoc programmes
16. Implementation of all National Health Programmes



### *Key Responsibilities of Staff at Health Post*

Responsibilities of all cadres of staff at health posts can be broadly divided into (*a*) clinical, (*b*) supervisory, and (*c*) administrative duties. Every staff member is required to play role in the implementation of all services provided by the health post. Each cadre of staff has specific strengths that make them valuable members of the health care delivery system. The clinical aspect of the services, i.e., diagnosis and treatment, is looked after by the medical officers. PHNs are the nodal persons in health posts and play the role of managers and organisers in the health care system. The roles of ANMs and MPWs differ only in that MPWs are required to reach out to men and adolescent boys in the community whereas ANMs can be more effective in reaching out to women and adolescent girls. The primary responsibilities of each cadre are presented below. Except

for medical officers, who head the staff at health posts and therefore have more supervisory and administrative responsibilities, the responsibilities of other staff are not differentiated under the three broad categories.

***Full-time Medical Officer***

*Clinical responsibilites*

- Conducting clinics for ANC, PNC, STI/RTI, child health and adolescent girls. Providing clinical services as per RCH norms

*Supervisory responsibilities*

- Updating technical knowledge of staff at health post. Monitoring health education sessions conducted by PHN, ANM and MPW, organising regular refresher training programme for CHVs, taking the initiative for ensuring the quality of health care services, supportive supervision, problem solving and team building.

*Administrative responsibilities*

- Ensuring that appropriate records are maintained for each of the programmes, checking the records and complied data, and ensuring availability of medicines.

***Public Health Nurse (PHN)***

- Assisting the medical officer in conducting clinics, conducting health education sessions and counselling
- Supervision of ANMs, MPWs and CHVs, conducting training for ANMs, MPWs and CHVs for capacity building, team building and problem solving.
- Administrative — compiling final reports, putting up indent.

***Auxiliary Nurse Midwife (ANM) and Male Multipurpose Workers (MPW)***

- Outreach, health education, identifying women from community in need of health care, referring them to health post, counselling, and assisting in conducting clinics.
- Supervision of CHVs, monitoring the quality of their work, inputs to CHVs to update their knowledge and problem solving
- Gathering information from community and preparing reports.
- MPWs should focus on men and boys for health education and ANMs on women and girls.

*Community Development Officers (CDO)*

- Planning various awareness programmes, organising meetings and delegation of tasks to health care providers,
- Coordination between community and health post and facilitating IEC activities.
- Supervision of health care providers from health posts and dispensaries and conducting refresher trainings on counselling and communication skills.
- Review and compilation of performance records.
- Documentation of special programmes, reports and managing correspondence.

Annexure 14.2

# Modifications in the RCH Module Based on Job Descriptions of all Cadres of Health Care Providers

## A. Changes in curricula for all cadres

**Full time Medical Officer in charge of dispensary, Public Health Nurse, Auxiliary Nurse Midwife (outreach)**, Male Multipurpose Worker**

| | |
|---|---|
| **Rationale** | FTMOs, MO i/c dispensary, PHNs, ANMs (outreach) and MPWs are outreach staff and are not responsible for providing abortion, intranatal services and services for the newborn. Through its experiences the project realised the need for developing perspective of BMC health care providers from all cadres on women's health and gender and the concept of quality of care. It was observed that the providers also lacked the requisite skills for counselling, group facilitation and health education. Sessions on these topics were therefore included to build relevant skills. Concepts relating to geriatric health at community level were imparted through the session on geriatric health. |
| **Topics omitted** | • Provision of services for safe abortion (practical aspect)<br>• Intranatal care<br>• Care of newborn |
| **Topics added** | • Perspective building on women's health and gender<br>• Planning for health education<br>• Infertility<br>• Counselling<br>• Group facilitation skills<br>• Quality of care<br>• Geriatric health |

These modifications were common to all cadres. However, there were other changes made to the curricula that were specific to cadres:

## B. Changes specific to each cadre

**Full-time Medical Officer, Medical Officer in charge of Dispensary, Male Multipurpose Worker**

| | |
|---|---|
| **Rationale** | Full-time Medical Officers and Medical Officers i/c of dispensaries are responsible for the implementation of various programmes through health posts and dispensaries. They also are responsible for supervising and managing the day-to-day work of PHNs, ANMs and MPWs. To help them fulfil their responsibilities more effectively, in addition to the sessions mentioned earlier, a session on supervision of and guidance to health workers was added to the ISDT for RCH. MPWs form the first link of the health delivery system |

| | |
|---|---|
| | with men at community level. They therefore play a crucial role in reaching out to men. WCHPs' experience of working with MPWs showed that they lacked clarity about this specific function. They also had no understanding of the strong linkages between gender and reproductive health and how to reach out to men to ensure gender-sensitive RH care. This session was included in the ISDT of RCH to discuss the specific roles that MPWs could play in various reproductive health conditions of women and men. |
| **Additional topics added** | • Supervision of and guidance to health workers<br>• Men's involvement in women's health. |

**Auxiliary Nurse Midwife (Maternity home)**

| | |
|---|---|
| **Rationale** | The job responsibility of the ANM (MH) is limited to nursing duties within the maternity home. She is not required to nor has the scope for planning health programmes. However, ANMs play a key role in giving information to clients. It was observed in WCHP's earlier studies ANMs (MH) have a poor understanding of the concept of gender and its effect on reproductive health, and this is reflected in their impolite attitude and communication with clients. Although they are required to conduct group health education sessions, most lack the confidence to do so. |
| **Topics omitted** | • Community Needs Assessment |
| **Topics added** | • Perspective building on women's health and gender<br>• Health education<br>• Demonstration on group facilitation skills<br>• Quality assurance |

**Full-time Medical Officers, Medical Officers i/c Dispensaries, Public Health Nurses**

| | |
|---|---|
| **Rationale** | Following a training conducted by WCHP on Reproductive and Sexual Health for adolescent, non-school-going girls, MCGM's PHD initiated a programme for adolescent girls. Called the 'Adolescent Girls' Initiative' (AGI), this programme is presently being implemented through all health posts and dispensaries. FTMOs and PHNs, who had already (2000–2001) been trained in issues relating to adolescent health, are the nodal persons for AGI. This session was therefore omitted from the training schedule for doctors and PHNs. However, ANMs and MPWs, who had not been trained earlier, were given the relevant inputs through ISDT for RCH |
| **Topics omitted** | • Adolescent Health |

ANNEX

T-14.1

# Proposed Session Plan for ISDT for RCH for Community Health Volunteers

| Day | 1st Session Time : 90 minutes | 2nd Session Time : 90 minutes | 3rd Session Time : 90 minutes | 4th Session Time : 90 minutes |
|---|---|---|---|---|
| 1 | Introduction to RCH | Reproductive System<br>• Women: Menstruation, Ovulation, Conception<br>• Men: Masturbation, Sexuality issues Other sexual problems | Reproductive System. Continued... | Health problems associated with the reproductive system such as menstrual disorders |
| 2 | ANC<br>• Risk factors<br>• Anaemia<br>• Referral<br>• Gender issues in ANC | ANC Continued... | PNC.<br>• Nutrition<br>• Weaning<br>• Immunisation<br>• Breast-feeding | PNC. continued...<br>• Gender issues in PNC |
| 3 | Sick child<br>• How to recognise<br>• Where to refer | Contraception<br>• Methods<br>• Side effects of each<br>• Gender issues | Contraception continued..... | Contraception continued..... |
| 4 | RTIs - STIs<br>• Symptoms<br>• Where to refer<br>• Prevention<br>• Myths and misconception<br>• Partner treatment | RTIs-STIs continued... | Infertility<br>• Male–female factors<br>• Emotional problems<br>• Referral<br>• Adoption services | Infertility continued... |
| 5 | Gender and Health<br>• How different diseases affect males and females differently<br>• Socio–clinical factors | Gender and Health Continued... | Community Participation and CNA<br>• Working with CBOs and NGOs<br>• Forming groups of men and women | • Adolescent Health<br>• Geriatric health<br>• Importance<br>• Gender issues |
| 6 | IPC. | Counseling | Communication for behaviour change | Health Education |

**Note:** * Orientation visit to hospital/maternity homes to be organised on one of the training days.

T-14.2

# Topics for Counselling and Interpersonal Communication

| Sr. No. | Programmes and Services | Interpersonal Communication and Counselling |
|---|---|---|
| 1 | Antenatal Care | • Antenatal care<br>• Early registration<br>• High-risk pregnancies<br>• Importance of regular check-ups<br>• Advantages and disadvantages of home deliveries<br>• Safe abortions (if the woman does not want to continue the pregnancy)<br>• Effects of RTI/STI on pregnancy<br>• Nutrition and rest<br>• Breast care<br>• Care of the newborn<br>• Men's role in ANC* |
| 2 | Post-natal Care | • Care of newborn<br>• Effective breast-feeding<br>• Immunisation<br>• Nutrition and rest<br>• Men's role in child rearing* |
| 3 | Family Planning | • Advantages and disadvantages of family planning methods<br>• Couple counselling<br>• (This information can also be given to women seeking ANC and PNC services) |
| 4 | RTI/STI | • Prevention<br>• Causes of RTI/STI<br>• Importance of the treatment<br>• Importance of partner treatment* |
| 5 | Infertility | • Causes of infertility<br>• Information on treatment procedures<br>• Importance of sperm count test*<br>• Importance of checking both husband and wife and their treatment*<br>• Importance of completing the treatment<br>• Emotional support to women<br>• Sexuality counselling*<br>• Information on adoption* |
| 6 | Child Health | • Immunisation<br>• Nutrition<br>• ORS/home remedies<br>• Diet in diarrhoea<br>• Nutritional advice for malnourished children<br>• Men's role in child-rearing* |
| 7 | Safe Abortion | • Importance of safe abortion<br>• Family planning methods — (advantages and disadvantages for each method)* |
| 8 | National TB Control Programme (RNTCP) | • Prevention of tuberculosis<br>• Treatment available for tuberculosis and importance of DOTS<br>• Gender issues in TB |

TOOL

| Sr. No. | Programmes and Services | Interpersonal Communication and Counselling |
|---|---|---|
| 9 | Disease Surveillance | • Prevention of seasonal epidemics |
| 10 | HIV/AIDS | • Prevention, spread of HIV/AIDS<br>• Counselling of AIDS patients and spouse or family if the patient desires |
| 11 | National Leprosy Programme | • Awareness on leprosy |
| 12 | Pulse Polio Immunisation | • Information on immunisation |
| 13 | Adolescent Girls/Boys Health Programme | • Nutrition<br>• Personal hygiene<br>• Importance of sex education<br>• Information of psychological and physical changes during adolescence<br>• Assertiveness and negotiation skills<br>• Emotional support<br>• Vocational guidance |
| 14 | Referral | • Information on various referral services<br>• Counselling of referred cases |

Note: All health workers can provide information and counselling on the topics mentioned above. However, the details and extent of technical information may vary with each level of health care provider. Points marked with '*' are especially important for discussion with men.

# NOTES

# NOTES

# NOTES

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